

GENERAL HEADQUARTERS
SUPREME COMMANDER for the ALLIED POWERS
PUBLIC HEALTH and WELFARE SECTION



Public Health and Welfare
in
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Public Health and Welfare in Japan

1945/48, pt. 1

-- Foreword --

Public Health and Welfare in Japan has been designed to portray the problems, activities and future programs of the Public Health and Welfare Section, General Headquarters, Supreme Commander for the Allied Powers, in furthering the health and welfare objectives of the occupational mission.

It provides a historical background and pre-surrender status of health and welfare in Japan, in addition to a factual review of the progress made from the beginning of the occupation through 31 December 1948.

Included herein as an Annex is a Provisional Summary of Health Statistics for 1948 and a Summary of Historical Health Data for Japan covering the period 1900 - 1948.

Tables

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Acknowledged

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ERRATUM

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should read:

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(Note: This pertains only to pages 48 through "Conclusion", page 61.)

On page 48, the paragraph heading, "Public Health Statistics", should read:

Chapter 2-A

PUBLIC HEALTH AND WELFARE STATISTICS

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SECTION I

HISTORICAL BACKGROUND

The National Level

The opening of Japan's door to the Western World in 1853 and the implantation of Western culture which followed, ultimately had a direct influence on the government's recognition of the necessity of providing for the health and welfare needs of its people.

During the ensuing 20 year period many unsuccessful attempts were made to adopt some form of a public health and welfare program. Finally in 1873 a Medical Bureau was established in the Department of Education and became the first such body created in Japan to control medical education and sanitary administration. The first unified statute called "The Medical Code" was published by this Bureau in 1874.

In 1875 the Medical Bureau was renamed the "Seventh Bureau" and transferred to the Ministry of Home Affairs where it became an agency for the exclusive management of sanitary activities. Later renamed the Sanitary Bureau, it was then subdivided into four sections: Health Preservation, Chronic Disease Prevention, Communicable Disease Prevention and Medical Affairs.

The first measures for the prevention of infectious diseases were taken in April 1875 by Imperial Decree No. 49 of the Supreme Council of the Empire (Regulations for the relief of the poor during the prevalence of epidemics).

In February 1876 Ordinance No. 12-B of the Home Department was enacted which instructed physicians to report the condition of patients attended by them, who were suffering from epidemic diseases.

Ordinance No. 16-A of the Home Department, passed in May of 1876, established regulations for the prevention of smallpox. Ordinance No. 79-B of the Home Department, passed in August of 1877, provided for preventive measures in cases of cholera. Imperial Decree No. 23 of the Supreme Council of the Empire, issued in June 1879, established provisional regulations for the prevention of cholera.

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Imperial Decree No. 23 also provided for Regulations for the Prevention of Infectious Diseases, the following diseases becoming reportable in July 1880: cholera, typhoid fever, dysentery, typhus, smallpox, diphtheria.

By Law No. 36, Prevention of Infectious Diseases, enacted in April 1897, plague and scarlet fever were made reportable in addition to the six infectious diseases listed above, at which time the Regulations for the Prevention of Infectious Diseases were abrogated.

Paratyphoid fever and epidemic meningitis were designated as infectious diseases in April 1911 and April 1918, respectively, and came under the provisions of Law No. 36.

While it might appear that the creation of the Sanitary Bureau and the preventive measures taken toward infectious diseases would foster the control of health and welfare activities, the Bureau's lack of authority and its inexperienced and incompetent staff failed to properly administer health and sanitary responsibilities. This retarded any worthwhile progress. It continued to function, however, with minor changes until 1938.

Prefectural and Local Organization

Prefectural and local programs for the administration of the Sanitary Bureau's responsibilities were vested with the prefectural governors, police chiefs, and chiefs of towns and villages. The Ministry of Home Affairs exercised indirect control and provided advisory guidance depending upon the matters involved. In routine affairs the prefectural and local organizations were invested with wide discretionary powers.

A health section, including laboratories, was attached to each prefectural police department to handle all public health activities. The head of the health section was appointed by the Ministry of Home Affairs with the approval of the Emperor. Cities, towns and villages had authority to adopt local public health ordinances. Municipal health officials were appointed by the mayor, with the consent of the local assembly, and cooperated with the chiefs of the police in administering and supervising sanitary matters.

Each village, depending on size, had a Sanitation Bureau or a Sanitation Officer who was responsible for all matters concerning sanitation. They enforced local sanitary ordinances and supervised vaccinations. In addition, the village officials maintained a doctor for preconception health examinations and annual smallpox vaccinations. Local police assisted village officials in carrying out their public health duties and were called upon to enforce rules which were not obeyed.

At the various levels of prefectural and local organizations, there was a considerable overlapping of the duties of the police and other civil administrative officials.

Public Health and Welfare in Japan

The Ministry of Welfare

Repeated attempts to encourage the establishment of a national governmental organization to be responsible for the over-all health and welfare problems of the nation had met with little success. However, the rapid industrialization of the nation following the Sino-Japanese, Russo-Japanese and the First World War, with its resultant booms and depressions, coupled with rice riots in 1918, forced the government's hand in establishing a national agency. In addition, the army was finding too many tuberculosis rejectees and became gravely concerned about the deterioration of the health of the young men eligible for military duty.

In 1937 the government decided to create a national organization and on 11 January 1938, by Imperial Ordinance No. 7, the Ministry of Health and Social Affairs (now known as the Ministry of Welfare) was established and made responsible for the health and welfare of the civilian population, labor administration and social insurance.

The Ministry was subdivided into the Ministerial Office with Divisions for Secretariat, General Affairs and Accounts; Bureaus for Physical Training, Sanitation, Preventive Medicine, Social Affairs, and Labor; and an Insurance Department with Divisions for General Affairs, Social Insurance and Post Office Life Insurance. The Ministry also controlled the National Hygienic Laboratory, the National Leprosarium, the National Juvenile Reformatories and the Infectious Disease Research Institute.

Following the establishment of the Ministry of Welfare the government transferred the Sanitation Bureau from the Ministry of Home Affairs to the new Ministry. All public health and welfare activities of the nation then became the responsibility of this Ministry. In the prefectural and local governments the original administrative setup was preserved but came under the authority of the Ministry of Welfare.

From 1938 to 1945 the Ministry of Welfare underwent several reorganizations. In April 1938 a Department for the Protection of Wounded Veterans was created to take care of the sick and wounded soldiers from the war in China. In 1938 this Department extended aid to the families of soldiers who were killed in action and simultaneously changed its name to the Department of Soldiers' Protection. In 1941 the Bureau for Physical Training became the Bureau for Population but two years later was renamed the Bureau for Health Promotion.

The Bureau for Preventive Medicine was abrogated in 1942 and its duties divided between the Bureaus for Physical Training and Sanitation. Meanwhile, the Bureau for Social Affairs was redesignated the Bureau for Livelihood but was later abolished in 1944 when its functions were transferred to the Bureau of Health Promotion. Likewise in 1942 a new Bureau for Occupation was established but the following year was changed to the Bureau for Labor Exchange. This same year the Insurance Department was abolished when the Post Office Life Insurance Section was transferred to the Ministry of Communications. The General Affairs Section was then abolished when the Social Insurance Section was changed to Bureau Status.

Public Health and Welfare in Japan

The constant administrative changes, plus frequent transfers of responsibilities, did little to perpetuate a good public health and welfare program.

World War II Administration

During the war increased industrialization and urbanization in the four main islands of Japan, plus the dominance of military aims over all social welfare activities, had a pronounced influence on public health and welfare administration.

Pressure of militarism brought greater emphasis on such emergency requirements as a rapid turn out of medical students, nurses and dentists. It also resulted in the cessation of many public health activities of benefit to the civilian population. The conversion of many factories, engaged in the manufacture of medical and sanitary supplies and equipment, to war materiel production, plus the lack of adequate professional people to serve the civilian population, resulted in a complete breakdown of all public health and welfare functions.

From the national to the lowest level the entire administration of public health and welfare activities became disorganized. Lack of trained personnel, low salaries and incompetent officials, charged with crucial responsibilities for public health, seriously affected the efficiency of the entire organization. In addition, the Ministry of Welfare had not been permitted to assume its proper place in the Japanese government and many of the activities generally associated with public health and welfare were the responsibilities of other Ministries.

Upon the arrival of the Occupation Forces, Japanese public health and welfare activities were found to be in a very demoralized state. An unsound administration, plus the nation's efforts to gear itself during the war, had completely broken down any semblance of health or welfare functions.

Note: A complete informational background of the health and welfare problems that confronted the Occupation Forces may be found under each specific subject in Section III.

SECTION II

PUBLIC HEALTH AND WELFARE SECTION

Mission and Organization

An organization to handle the public health and welfare problems which were expected to be encountered in Japan following the planned invasion was organized in May 1945, in Washington, D. C. This provided for a Military Government Section of General Headquarters, United States Armed Forces, Pacific (GHQ USAFPAC) which included a Public Health and Welfare Division.

In August of 1945, at Manila, Military Government Section of GHQ USAFPAC was established, but the sudden capitulation of the Japanese Government resulted in a modification of this plan shortly after arrival of the Occupation Forces in Japan. Military Government Section of GHQ USAFPAC was abolished and General Headquarters, Supreme Commander for the Allied Powers (GHQ SCAP) established.

Personnel of Public Health and Welfare Division of Military Government Section were transferred to the Public Health and Welfare Section of SCAP which was established on October 2, 1945, by authority of General Order No. 7, GHQ, SCAP. The Section was made responsible for the prevention of widespread diseases and unrest in the civil populations of both Japan and Korea. Korea has since been deleted from SCAP control and, at the same time, SCAP assumed the responsibility for technical supervision over Military Government activities in the Ryukyus Islands.

The Public Health and Welfare Section was also made responsible for the establishment or reestablishment of normal health control procedures, and with expediting the establishment of essential public health and welfare activities. It was charged with requiring the agencies of the Japanese Government "to establish such standards of health, sanitation and quarantine in connection with repatriation of displaced persons as will prevent interference with the success of the occupation mission."

The Section is required to coordinate for SCAP all essential reports pertaining to health and welfare. It is also responsible for the production and distribution of medical, dental, veterinary, and sanitary supplies and equipment and the proper disposal of narcotic stocks, as well as the control of production and traffic in narcotics.

Public Health and Welfare in Japan

The Section recommends and directs the conduct of such surveys of public health and welfare activities as are essential to keep the Supreme Commander factually informed, and prepares instructions for the initiation, coordination and development of such plans and programs as are required to meet the public health and welfare objectives.

The Section is organized into 10 divisions and 27 branches (Ref. chart 1) which cover all of the activities of the Ministry of Welfare, Japanese Government, thus permitting close coordination of all programs and activities necessary for an adequate public health and welfare organization.

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    A --> C[EXECUTIVE]
    B --> D[PREVENTIVE MEDICINE DIVISION]
    B --> E[NURSING AFFAIRS DIVISION]
    B --> F[SUPPLY DIVISION]
    B --> G[MEDICAL SERVICES DIVISION]
    B --> H[ADMINISTRATIVE DIVISION]
    B --> I[HEALTH STATISTICS DIVISION]
    B --> J[SOCIAL SECURITY DIVISION]
    B --> K[WELFARE DIVISION]
    D --> D1[SANITARY ENGINEERING BRANCH]
    D --> D2[LABORATORY BRANCH]
    D --> D3[VENEREAL DISEASE CONTROL BRANCH]
    D --> D4[TUBERCULOSIS CONTROL BRANCH]
    D --> D5[VIRUS & RICKETTSIAL DISEASE CONTROL BRANCH]
    E --> E1[NURSING EDUCATION BRANCH]
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    H --> H1[PERSONNEL BRANCH]
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    J --> J2[SOCIAL INSURANCE BRANCH]
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SECTION III

PUBLIC HEALTH AND WELFARE PROGRAMS

Chapter 1

JAPANESE ADMINISTRATION

Reorganization of the Ministry of Welfare

To permit the Ministry of Welfare to assume its proper place in the Japanese Government, with sufficient authority and responsibility to carry out necessary public health and welfare objectives, SCAPIN 945 (SUPREME COMMANDER for the ALLIED POWERS INSTRUCTIONS) dated 11 May 1946, directed the Japanese Government to immediately reorganize the administration of health and welfare activities by establishing the following bureaus:

1. Bureau of Health - to be responsible for public health, health education, vital statistics and nutritional activities.
2. Bureau of Medical Treatment - to be responsible for administration of hospitals, sanatoria, leprosaria, medical affairs, medical relief programs, pharmaceutical affairs, drug production and pharmaceutical standardization.
3. Bureau of Preventive Medicine - to be responsible for sanitary engineering, communicable and chronic infectious diseases.
4. Bureau of Social Affairs - to be responsible for public assistance, public welfare and the procurement and disposition of materials necessary to implement such functions.

The Ministry was given the full responsibility for the production and distribution of all medical and sanitary supplies and equipment, including the control of narcotics. A Children's Bureau has also been established and is responsible for child problems, including

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maternal and infant care. The reporting of Vital Statistics, which had been the responsibility of the Cabinet Bureau of Statistics, was transferred to the Ministry of Welfare.

In July 1948 a further reorganization of the Ministry of Welfare took place, in which a re-grouping of the various departments, bureaus and sections provides for more efficient coordination of the nationwide public health and welfare program. A new Pharmaceutical and Supply Bureau was organized, replacing the Pharmaceutical Affairs Section, Drug Manufacturing Section and the Supply Section, formerly under the Medical Affairs Bureau. A Public Sanitation Bureau replaced the former Public Health Bureau, and elevated to section status were the Food Sanitation Section, the Veterinary Affairs Section and the Environmental Sanitation Section.

The reorganization also included the changing of the First Demobilization Bureau to the Repatriation Relief Agency, responsible to the Minister of Welfare.

As now organized (Ref. chart 2), the Ministry provides for a logical grouping of the four basic functions essential to an adequate national health and welfare program; preventive aspects of public health, medical care, social welfare and social security.

One of the significant changes in the reorganization of the Ministry of Welfare concerns the former career government employees who were required to be graduates of the Tokyo University School of Law and, as career officials, controlled all key positions in the National Government down to and including bureau chiefs. These former officials have been replaced by qualified professional personnel who now head the various activities in the government, including the Ministry of Welfare.

Prefectural and Local Reorganization

SCAPIN 945 further directed the Japanese Government to establish in each prefecture a Department of Health and a Department of Welfare whose functions will include those as outlined in the Ministerial Bureaus and to act as the operating agency for prefectural public health and welfare activities. Under the supervision of the prefectural welfare departments an organization of social welfare workers was established to administer provisions of the welfare programs.

In conjunction with the reorganization of the Ministry of Welfare and the prefectural governments, a program was initiated to provide for the reorganization of nationwide health centers, not only to include the 12 basic services considered essential, but to make health center districts the basic administrative units in the over-all national public health and welfare program.

MINISTRY OF WELFARE

MINISTER OF WELFARE

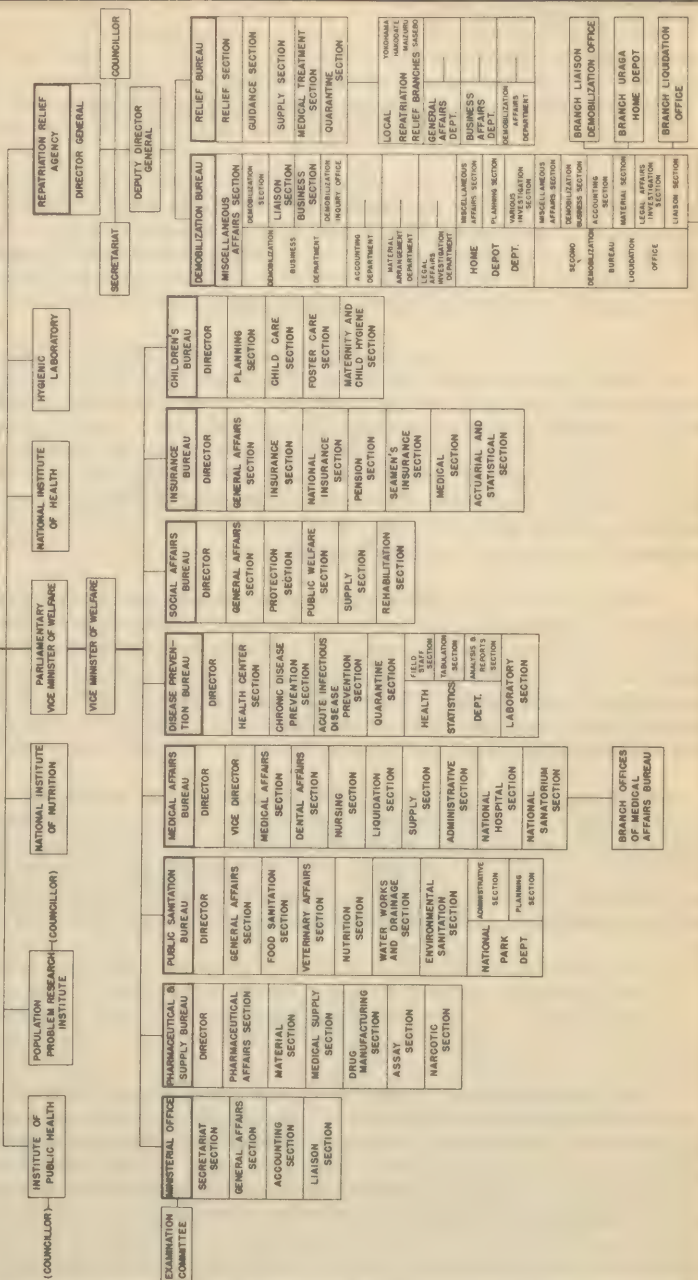


Chart 2

Public Health and Welfare in Japan

The Health Centers

Japan's Original Health Center Program

In the early 1930's, the Ministry of Home Affairs established a small number of health guidance centers throughout Japan. The exact purpose and function of these centers is somewhat vague although the best available information indicates that they served primarily to offer guidance to the general public on health matters and also carried out limited examinations for tuberculosis.

In 1937 the first health center law was enacted which established a national health center system. The former health guidance centers became known simply as health centers, in addition to a number of other health clinics which were formally established as health centers. By 1938, 50 such health centers had been established in various parts of Japan. The primary function of these health centers was the advancement of health education and examination and guidance to tuberculosis patients. They also offered some maternal and child welfare guidance. However, they had no administrative power.

The health center facilities varied from large, well constructed buildings, strategically located, to small, deteriorated buildings, poorly located with no adequate administrative organization. They were sponsored by the national government but were under the control of the prefectural government. They functioned poorly, suffered from lack of trained personnel and proper supplies and equipment, and generally contributed little to the public health.

Additional health centers were established each year until one health center had been established for each gun (county) or ward, in case of the larger cities, throughout Japan. There were approximately 645 health centers in existence at the beginning of the Occupation, many of which have been damaged during the war or had deteriorated to such an extent that they were useless.

Reorganization

The health center organization was recognized as having great potential value in the control of communicable diseases, improvement of environmental sanitation, and in promoting the general public health. Because it was necessary that Public Health and Welfare Section and Japanese public health officials occupy themselves in the control of acute communicable diseases and other work of an emergency nature during the first year of the Occupation, it was not possible to devote a great deal of attention to the reorganization of the health centers. They were, however, permitted to continue their activities in accordance with the then existing health center law.

Public Health and Welfare in Japan

Early in 1947, when the urgency of controlling various communicable diseases diminished, action was initiated to expand and improve the functions of the health centers. Japanese officials had a poor conception of what the services of a modern health center should consist, so accordingly, the Japanese Government was directed to present appropriate reorganization plans to include the following 12 basic public health services:

1. Public health nursing
2. Maternal and child hygiene
3. Public health statistics
4. Public health laboratory services
5. Dental hygiene
6. Nutritional services
7. Sanitation and hygiene
8. Health education
9. Medical social service
10. Communicable disease control
11. Venereal disease control (including diagnosis and treatment)
12. Tuberculosis control (including diagnosis and treatment)

After considerable planning a new Health Center Law (Public Law 101) passed the Diet on 5 September 1947. In addition, an enforcement ordinance, an enforcement regulation, and enforcement instructions were issued by the Ministry of Welfare to all prefectural governors, setting forth all the requirements of this new Health Center Law. A supplemental budget provided for increases in personnel and equipment.

It was then anticipated that rapid expansion and improvement of health centers would follow. However, the 1947 Local Autonomy Law, which decentralized powers of the national government, caused some confusion with respect to the authority of the local governors in implementing the Health Center Law. In order to clarify the situation the Local Autonomy Law was amended on 7 December 1947 leaving the way clear to reorganize and expand the health centers and to establish health center districts as originally planned.

The health centers are the logical administrative and service units for carrying out the details of the nation's public health program at the local level. They are a fundamental part of the public health organization, since they are that part of the organization with which the public is most intimately associated.

Public Health and Welfare in Japan

The Model Health Center Demonstration

In order to provide key Japanese public health and welfare personnel with the modern concepts of how a health center should function, Public Health and Welfare Section arranged a model health center demonstration in Tokyo in March 1948. The health center selected was reconditioned and competently staffed and equipped to provide all the essential basic services.

Military Government public health officers, public health nurses, welfare officers and sanitary officers from each team in Japan and selected Japanese national and prefectural public health and welfare officials from each of the 46 prefectures were invited to attend.

The program consisted of six, one-week each, demonstrations which were given to some 400 persons. Visual and auditory aids were extensively used; lectures included both demonstration and application of health center activities.

The six courses were enthusiastically attended and provided Japanese personnel an opportunity to observe the physical and equipment facilities and functions of a modern public health center in action. They were then directed to establish a similar model health center in each prefecture in Japan as a basis for the prefectural health center reorganization program to follow.

The Current National Program

Health Center Districts - Health center districts have been established within the 46 prefectures of Japan with one district for approximately each 100,000 population (800 in all). These health center districts administer the health laws and programs on the local level and will, when the organization is completed, contain at least one completely organized and staffed health center and as many branches as may be required by the distribution of the population within the district. The Chief of the health center district (doctor) is under the supervision of the Chief of the Prefecture Health Department. In the case of cities in which there is located more than one health center district, a City Health Department is established, which in turn supervises the district health officers. The Chief of the City Health Department is under the technical supervision of the Prefecture Health Department Chief.

Model Health Center - A model health center has now been established in each prefecture in Japan. This health center serves the public health needs of the district in which it is located. It also serves as a model for the establishment and operation of similar health centers throughout each prefecture. In addition, it serves as a teaching center for the training of all categories of health center personnel serving within the prefecture.

The staff of a model health center, to carry out the basic functions enumerated above, consists of eight doctors, one dentist, two dental

Public Health and Welfare in Japan

hygienists, 15 public health nurses, 1 midwife, 1 public health veterinarian, 13 sanitarians, 3 pharmacists (which in Japan includes individuals who are in fact medical supply personnel), 1 nutritionist, 1 X-ray technician, and 63 miscellaneous personnel, totaling 109. (Ref. chart 3) The staff of the health center also functions as the staff for the district health officer in administering the health programs within his district. Four sections with 17 divisions have been established. The chart gives a clear picture of the functional organization and the manning table for the health centers.

There are two divisions which particularly should be noted. A Medical Affairs Division has been established in order to integrate the preventive medicine functions of the health center with the medical care facilities within the district, by establishing liaison with the local medical association and medical care facilities, such as doctors' offices, hospitals and sanatoria. This division is also charged with the responsibility of carrying out inspection of medical care facilities for minimum standards established under the new Medical Services Law.

The Division of Medical Social Service acts as a link between the preventive medicine functions of the health center and the welfare and social security organizations within the district, performing the same liaison functions with these organizations as does the Medical Affairs Division with the medical care facilities.

The reorganization, expansion, and improvement of health centers will proceed as rapidly as funds and personnel become available. Already a number of prefectures have made considerable improvement in their health centers and some additional health centers have already been raised to model status.

The success of the national public health and welfare program is largely dependent upon its administrative organization. The Ministry of Welfare at the national level and the prefectures at the prefectural level have now been reorganized.

Reorganization of the health centers is the third and final step in the reorganization of the nation's public health and welfare system. The establishment of the model type health center districts in each prefecture and the organization of the health center districts will be pushed to completion to provide for continuous uniform public health administration at all levels of government.

ORGANIZATION AND PERSONNEL OF HEALTH CENTERS IN JAPAN

ORGANIZATION		PERSONNEL											
		PHYSICIANS	DENTISTS	DENTAL HYGIENISTS	PUBLIC HEALTH NURSES	MIDWIVES	VETERINARIANS	SANITARIANS	PHARMACISTS	NUTRITIONISTS	X RAY TECHNICIANS	NON PROFESSIONAL EMPLOYEES	TOTAL
* DIRECTOR (PHYSICIAN)	GENERAL AFFAIRS	1*										5	6
												2	2
									1			1	2
	SANITATION							3				40	3
								8				1	48
								2	1			1	5
	FOOD AND ANIMAL DISEASE CONTROL												
	COMMUNICABLE DISEASE CONTROL	1										3	4
	TUBERCULOSIS CONTROL	2									1	1	4
	VENEREAL DISEASE CONTROL	1										1	2
HEALTH PROMOTION AND PREVENTION	PREVENTION											1	1
	MATERNITY AND CHILD HYGIENE	1				1							2
	DENTAL HYGIENE		1	2									3
	NUTRITION								1			1	2
	HEALTH EDUCATION											1	1
PUBLIC HEALTH SERVICES	PUBLIC HEALTH STATISTICS	1										3	4
	PUBLIC HEALTH NURSING				15								15
	MEDICAL SOCIAL SERVICE											1	1
	LABORATORIES	1							1			2	4
TOTAL		8	1	2	15	1	1	13	3	1	1	63	109

(3) DATA FROM CHART NO. 1-5, 10-12, 1954

Chapter 2

PREVENTIVE MEDICINE

Communicable Disease Control

Japanese standards of sanitation and public health practice were, in most all instances, far below those of the more progressive nations. Standards they had attempted to maintain had been allowed to deteriorate due to the diversion of labor and materials to the war effort.

Public water supply and waste collection facilities had been severely damaged in the areas that were bombed. Those that escaped the devastation of war were badly deteriorated through neglect and shortages of material and supplies.

Vaccination programs against such diseases as smallpox were either completely discontinued or were not enforced. Environmental sanitation was virtually non-existent presenting a definite threat of epidemics of diarrhea, dysentery, typhoid and other enteric diseases.

Smallpox

Smallpox was the one disease which was controlled by a fairly adequate existing law. However, enforcement had not been carried out during the war years and, as a result, a large portion of the population was found to be non-immune. The incidence of smallpox had been steadily increasing since 1940 and upon arrival of the Occupation Forces was found to be increasing rapidly.

The need for prompt and vigorous control measures was recognized, however, vaccine was not immediately available and there were many problems that had to be solved before adequate amounts of a satisfactory vaccine could be manufactured and made available.

Steps were taken to control local outbreaks, but this was not sufficient to prevent an epidemic which developed rapidly and reached its peak in March 1946, when a total of 6,304 cases were reported for that month alone.

Smallpox vaccine was produced as rapidly as possible. Wide scale immunizations succeeded in bringing the epidemic under control during the spring and early summer of 1946, but not until more than 17,000 cases had occurred among the civilian population. Although cases occurred throughout Japan, the prefectures of Hokkaido, Tokyo, Kyoto, Osaka and Hyogo had by far the highest rate. During the spring of 1946, a large scale immunization program was carried out in which the entire 78,000,000 people in Japan were vaccinated. This was one of

Public Health and Welfare in Japan

the largest mass immunization programs ever attempted and illustrates the effectiveness of immunization in rapidly bringing under control one of the most dreaded of communicable diseases.

This mass immunization program has practically eliminated smallpox as a major public health problem. A small number of cases have continued to occur, most of which have been sporadic and only in a few instances have there been more than one or two cases in an area.

The control program in effect involves the immunization of the entire village or town when a case of smallpox occurs. Large outbreaks have thus been prevented. In addition, to focal immunizations, the routine immunization program for infants and children has been carried out in conformance with the new immunization law.

The effectiveness of the present control program is demonstrated by the fact that only 29 cases, all sporadic, were reported during 1948. (Ref. chart 4 and tables 13, 14, 23, 24)

The Preventive Vaccination Law passed by the Diet on 1 July 1948 requires smallpox immunization in infancy and re-immunization before entering school and again at the completion of elementary school. The law further provides that in cases of threatened epidemics all persons living in the threatened area will be immunized or re-immunized.

Smallpox is no longer a major public health problem. Future programs designed to eradicate this disease consist of focal immunizations where cases occur, and routine immunization and re-immunization of infants and children in conformity with the existing law.

Typhus

Diseases of the typhus fever group, notably Tsutsugamushi fever (scrub typhus) and epidemic (louse-borne) typhus, have been endemic in Japan for many years. Unfortunately in case reporting, no distinction was made between epidemic (louse-borne) and murine (flea-borne) typhus so that the exact incidence and distribution of these diseases was not determined. The incidence and distribution of Tsutsugamushi fever, on the other hand, was quite well known. During the past eight years the reported incidence for all typhus fevers, and for those due to Tsutsugamushi alone were as shown in the following two tables:

Typhus Fever Group (Inclusive)

<u>Year</u>	<u>Cases</u>	<u>Case Rate*</u>	<u>Deaths</u>	<u>Death Rate*</u>
1941	87	0.1	37	0.1
1942	100	0.1	66	0.1
1943	1374	1.9	183	0.2
1944	3941	5.4	622	0.9
1945	2392	3.5	259	0.4
1946	31141	41.5	2909	3.9
1947	1114	1.4	216	0.3
1948	474	0.6	30	0.04

SMALL POX: JAPAN, 1938-1948

MONTHLY RATE —
CASES YEARLY RATE —

DEATHS —
MONTHLY RATE ---
YEARLY RATE ---

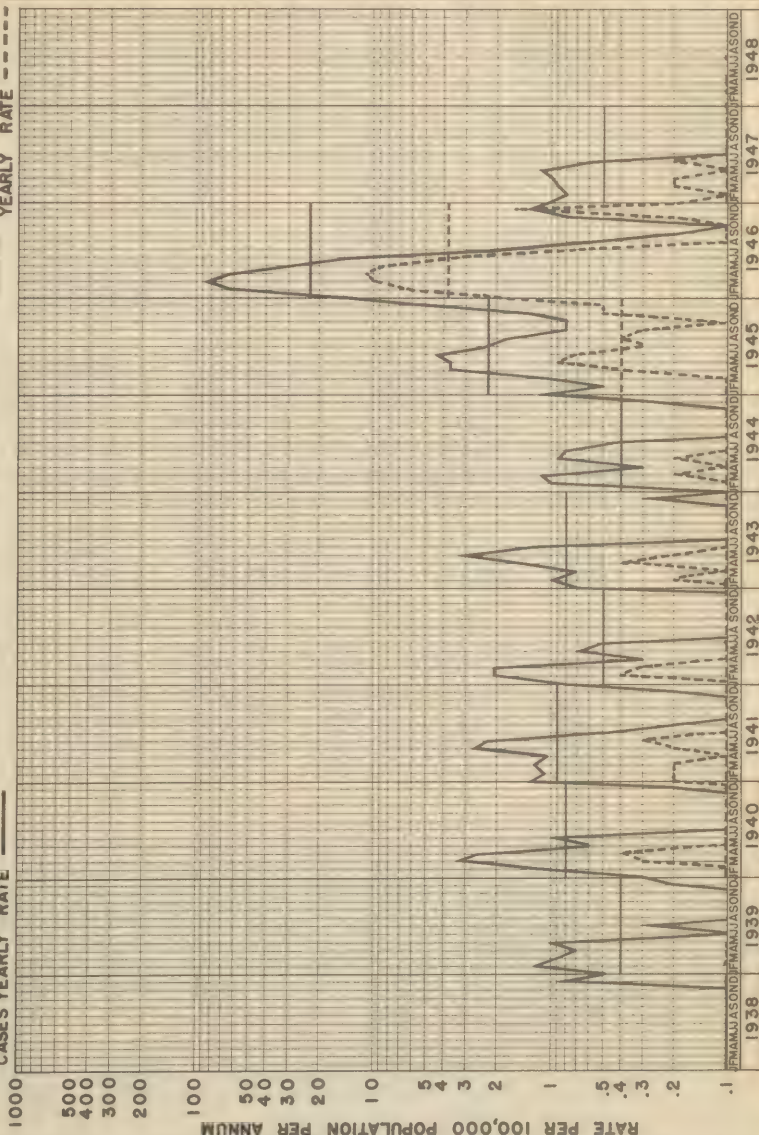


Chart 4

Public Health and Welfare in Japan

Tsutsugamushi Fever*

<u>Year</u>	<u>Cases</u>	<u>Case Rate*</u>	<u>Deaths</u>	<u>Death Rate*</u>
1941	45	1.44	16	.51
1942	80	1.85	33	.75
1943	55	1.74	23	.73
1944	62	2.04	22	.72
1945	35	0.97	13	.36
1946	31	0.88	10	.28
1947	50	1.26	21	.53
1948	45	1.21	5	.13

*Ministry of Welfare figures based on cases and deaths per 100,000 population.

Most of the cases (epidemic) in 1945 centered in Hokkaido where it was supposed to have been imported by Korean laborers. Tsutsugamushi fever was centered in Niigata and Akita prefectures; the last case reported from Yamagata prefecture occurred in 1942. During the past eight years this disease was reported in these three prefectures as follows:

<u>Year</u>	<u>Yamagata</u>		<u>Akita</u>		<u>Niigata</u>	
	<u>Cases</u>	<u>Deaths</u>	<u>Cases</u>	<u>Deaths</u>	<u>Cases</u>	<u>Deaths</u>
1941	0	0	8	4	37	12
1942	1	0	13	9	66	24
1943	0	0	6	1	49	22
1944	0	0	15	1	47	21
1945	0	0	13	4	22	9
1946	0	0	5	5	26	5
1947	0	0	6	3	44	18
1948	0	0	9	3	36	2

Areas infected with a mild type of scrub typhus were recently (1948) rediscovered in Shizuoka and Yamanashi prefectures on the lower slopes of Mt. Fuji. Previous reports (1934) of the former Japanese Army indicate that the disease existed among Japanese troops stationed in these areas. Civilian health authorities were apparently unaware of this since no civilian cases had been reported. Based on recent studies and investigations, murine typhus, with few exceptions, is found to be present in the same general locations as epidemic typhus.

Following the confirmation of the presence of epidemic typhus fever in Hokkaido in October 1945, control measures were promptly initiated in an effort to prevent a wide-spread epidemic. An attempt was made to check the spread of typhus across the Tsugaru Straits into Honshu. Although these efforts were effective when once put into operation, the action came too late to prevent the introduction of the disease into Honshu by infected persons traveling from Hokkaido to Honshu in an effort to reach their homes prior to the arrival of the Occupation Forces.

The disease extended southward and in December 1945 reached epidemic proportions in Osaka. The epidemic spread rapidly to Kobe, Nagoya, Tokyo and vicinities where the majority of the cases occurred. A total of 29,939 cases were reported between 1 January and 1 July 1946.

Public Health and Welfare in Japan

Typhus vaccine, DDT and other control supplies were not available from indigenous sources and had to be imported from the United States. An extensive program was begun in January 1946. Despite the handicap of inadequate supplies and improperly trained Japanese public health personnel, control measures were vigorously pursued and the epidemic abruptly halted. The peak was reached in March 1946 instead of May, the peak month of previous years. A total of 32,435 cases were reported between 1 September 1945 and 31 August 1946. (Ref. chart 5 and tables 13, 14, 23, 24)

Case finding teams, vaccinating teams, DDT dusting teams and insect and rodent control teams played a very important part in the typhus control program. Approximately 17,000,000 people were dusted with DDT and 5,300,000 were vaccinated during the first year of the occupation. Education of the public through the media of radio, press, pamphlets and posters and other visual aids was promoted with great success.

In 1947 control measures which had worked so successfully were continued and expanded. Under supervision, Japanese personnel have been most effective in carrying out this program. Between 1 January 1947 and 31 December 1947, a total of 1114 cases of typhus fever were reported as compared to the 31,141 cases reported during 1946. (Ref. chart 5 and tables 13, 14, 23, 24)

Although a large portion of the typhus vaccine initially used was imported from the United States, the Japanese were instructed in the preparation of the vaccine and produced considerable quantities for which minimum standards were established. This enabled them to meet all further requirements without the necessity of additional imports. Large quantities of DDT powder and spray were used during the second year of the occupation, the great bulk of which was manufactured in Japan.

Between 1 January and 31 December 1947, approximately 18,328,115 persons were dusted with DDT including a large number of school children whose heads were dusted in order to control head lice. DDT dusting stations were established in nearly every large city of Japan in addition to those conducting routine dusting operations in quarantine stations, various institutions and in the neighborhood of reported typhus cases. DDT residual spray and rickettsicidal spray operations were carried out at 30-day intervals in prisons, reformatories, jails, detention rooms, dormitories, railway stations, theaters, orphanages, public baths, railway coaches, busses, street cars, and miscellaneous conveyances including vessels and ferries.

During 1947 approximately 13,876,000 immunizing doses of vaccine were administered in which approximately 11,200,000 cc of vaccine were used (includes .5 cc amounts given to children 5 years of age or under). Extensive immunization was conducted on commuters in the larger cities, railway employees, quarantine personnel, inmates of prisons, residents of areas in which typhus cases occurred and miscellaneous groups.

On 15 December 1947 a small outbreak of typhus fever occurred in Osaka in which 27 cases were subsequently reported from one ward of the city. Control measures were effective and no further cases developed after 7 January 1948 when the last case was reported.

TYPHUS FEVER: JAPAN, 1938-1948

CASES YEARLY RATE ———

MONTHLY RATE ———

DEATHS YEARLY RATE - - - -

MONTHLY RATE - - - -

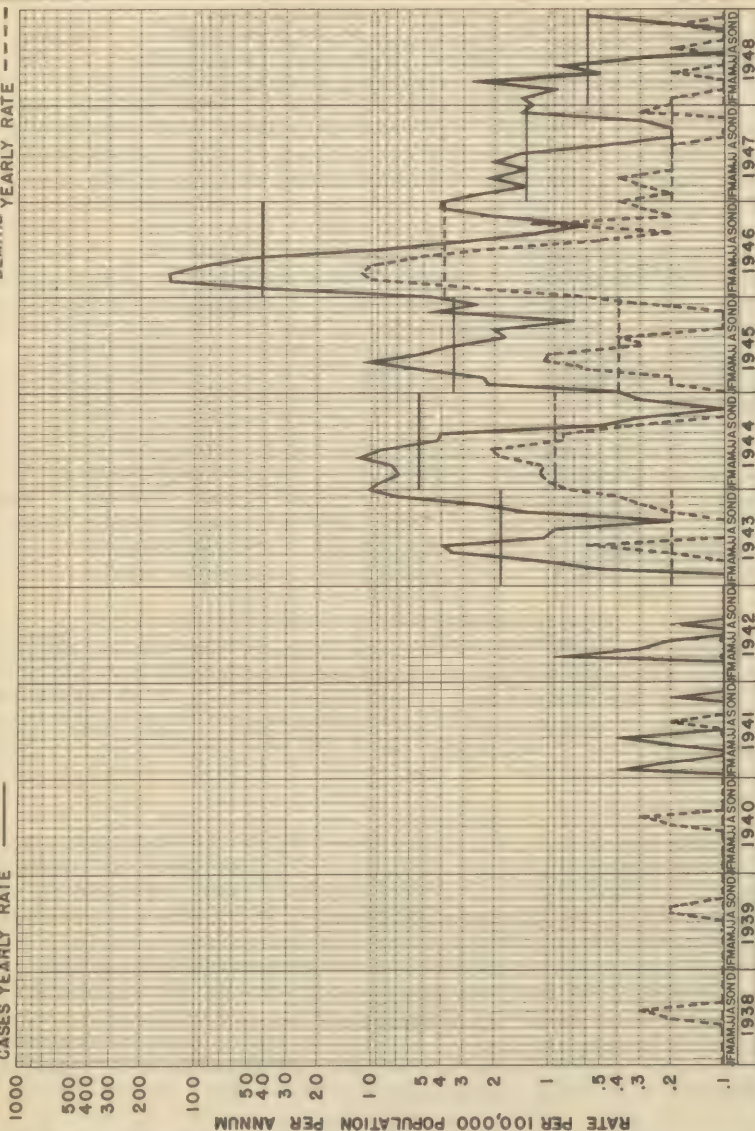


Chart 5

Public Health and Welfare in Japan

Control measures continued in 1948 with approximately 7,200,000 persons being dusted in addition to residual spray operations. Immunization programs included the same groups as in 1947, and although not quite as extensive, approximately 7,928,000 doses were given.

Dusting and spraying activities during this two year period consumed 3,211,355 pounds of 10% DDT dust and 1,234,621 gallons of 5% DDT residual effect spray.

In 1948 additional improvements in typhus control techniques were made. Intensive training courses for the benefit of Japanese prefectural health officers, laboratory technicians and other public health personnel were conducted covering the important phases of diagnosis, serology and control. Dissemination of information, concerning typhus fever, lice, fleas and rodents, to the people of Japan through all available media of transmission was continued. Case finding was intensified and case reporting was accelerated. Serological tests were made of serum samples taken from many of the suspect cases. Results of 257 suitable specimens submitted for examination showed 51.0% to be positive and 49.0% negative. Of the positive specimens, 47.5% were epidemic typhus, 29.3% were murine typhus and 23.2% were of undetermined type.

A total of 474 cases of typhus fever were reported in 1948 with a peak of 96 cases in January; however, in late March an outbreak of typhus fever was reported from a mental hospital in Osaka resulting in the occurrence of 98 cases. Control measures were effectively applied and no further cases were reported after 12 April.

The Preventive Vaccination Law also provides for immunization or re-immunization against typhus fever in the event of a threatened outbreak.

Research projects initiated in 1947 were continued during 1948. The two principal projects now in progress include studies to determine the relationship (if any) between murine and epidemic typhus fever, and the differentiation of types of typhus reported among Japanese nationals by use of complement-fixation and rickettsial agglutination tests. From the serological studies performed on serum samples obtained from 405 of the 474 reported cases in 1948, the following interesting results were obtained.

Number of Cases Confirmed

<u>Region</u>	<u>Epidemic</u>	<u>Murine</u>	<u>Undetermined</u>	<u>Total</u>
Hokkaido	1	3	0	4
Tohoku	18	0	0	18
Kanto	18	5	8	31
Tokyo-Kanagawa-Shizuoka	15	19	15	49
Kinki	155	15	24	194
Tokai-Hokuriko	10	29	18	57
Chugoku	3	10	3	16
Shikoku	0	3	0	3
Kyushu	6	13	11	30
Unknown	2	0	1	3
Total	228	97	80	405

Public Health and Welfare in Japan

Typhus control programs will continue with certain modifications in the dusting, spraying and immunization procedures as indicated by the typhus incidence. Dusting programs will be conducted on a year-round basis in congested areas of cities where the louse population density tends to remain consistently high. School children will continue to receive close inspection and dustings as needed, with dusting of the homes of children found infested. Greater emphasis will be placed on preventive dustings of inmates of orphanages, old peoples homes, dormitories, jails, detention rooms, certain hospitals, and persons found in vagrant camps. Pre-dusting operations against fleas will be encouraged prior to rodent control campaigns which will also be conducted throughout Japan. In the areas where scrub typhus exists, preventive and control measures will be placed in effect early in the season.

Research on the various phases of typhus will continue as conditions permit. Research problems now in progress include the continuation of (1) investigations to identify the "undetermined" type of typhus present in Japan, (2) continuance of serological studies on serum taken from reported suspect cases and clinically recognized cases of typhus, (3) continuance of work on the relationship which may exist between epidemic and murine typhus fevers, and (4) possible chemotherapy of typhus fevers with new preparations reportedly of value in the treatment of this group of diseases.

Diphtheria

Diphtheria has been extremely prevalent in Japan at least since 1900. (Ref. tables 13, 14, 23, 24) From 1937, when 28,001 cases were reported, the rate increased yearly with 94,274 cases reported in 1944.

While the Japanese had produced some diphtheria anti-toxin it was used only for treatment, and in a few cases, passive immunization. They had never used toxoid for prophylactic immunization. As a result of these circumstances diphtheria was primarily a children's disease with approximately 70% of the cases and 90% of the deaths occurring in children 10 years of age and under.

Statistics indicated that for the seven years preceding 1946 there had always been a peak case and death rate during the months of November and December. (Ref. chart 6)

The necessity for a nation-wide immunization program for the children was immediately recognized but the non-availability of toxoid and the inability to produce or procure toxoid made it impossible to conduct necessary immunization of children during the winter season of 1945 and 1946.

Japanese pharmaceutical manufacturing agencies were provided with instructions and the technique for the preparation of diphtheria toxoid and were directed to prepare an amount sufficient to immunize the nation's 18,000,000 children of 10 years of age and under. While awaiting production, reporting was re-established and preventive measures such as

DIPHTHERIA: JAPAN, 1938-1948

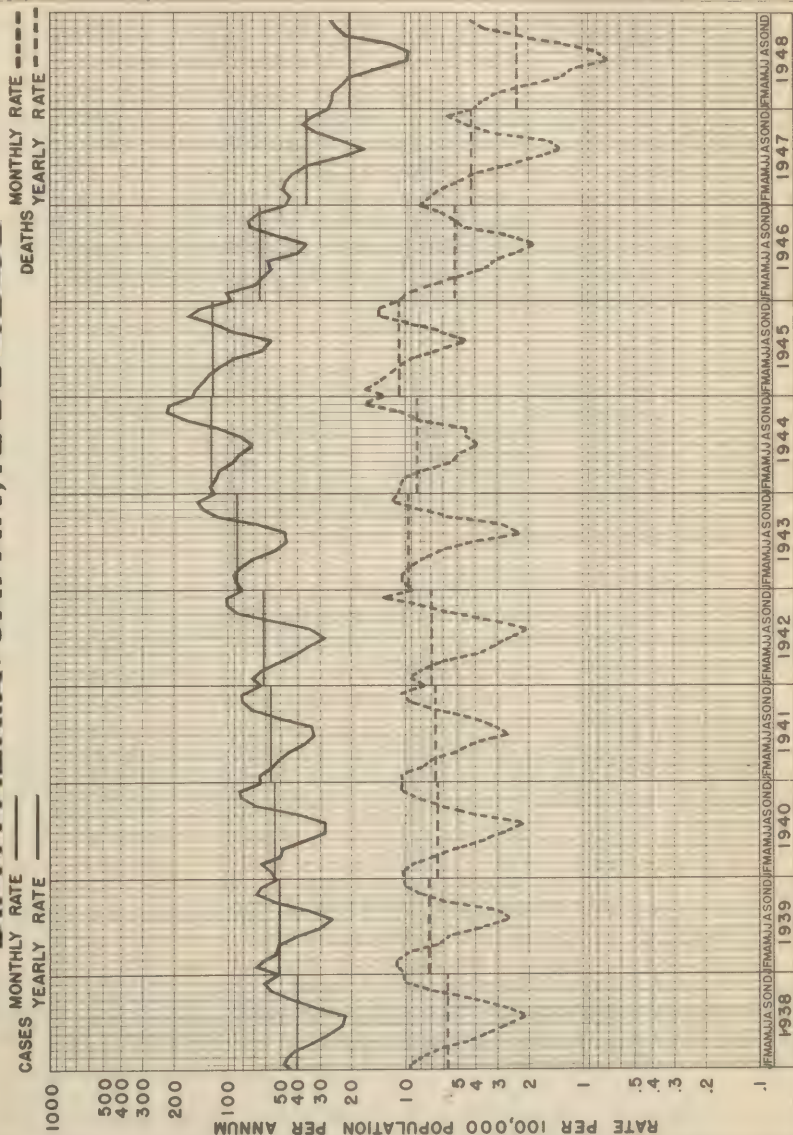


Chart 6

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isolation, quarantine and focal immunizations were carried out. These measures resulted in the number of cases being reduced to approximately 66,000 during the first occupational year.

With production accelerated sufficient diphtheria toxoid was prepared during the spring and summer of 1946 to meet scheduled plans for this immunization program to get underway by September. Approximately 16,000,000 children received immunizations, but the administration had many defects and many of the children did not receive the complete course or the required amount of vaccine. Nevertheless, the number of cases during the second occupational year was reduced to approximately 36,000 or a 46% reduction as compared to the approximate 66,000 reported during the first year of the occupation.

While the incidence of diphtheria continued to decline, the rate remained too high. (Ref. chart 6) A second nation-wide immunization program which was planned to further reduce diphtheria incidence was hampered by difficulties involving production and assay of vaccine. Although delayed, the program was started according to plans which provided for complete immunization (3 inoculations) of all children between the ages of nine months and ten years who had not been previously immunized and a single booster dose for those in this age group, previously vaccinated.

The Preventive Vaccination Law provides for compulsory immunization against diphtheria for all children between the ages of 6 to 12 months, and reimmunization within six months before entering elementary school, and again, six months before completion of elementary school. The law further provides for immunization or re-immunization in the case of threatened epidemics.

The second nation-wide immunization program, together with immunizations performed under the Preventive Vaccination Law resulted in a still further decrease in the incidence of diphtheria. The case rate in 1948 was 20.3/100,000/annum, as compared with the 1938-1945 mean of 75.5/100,000/annum. (Ref. chart 6 and table 24)

Present control procedures consisting of immunizations, isolation and treatment of cases are to be continued.

The difficulties surrounding production, assay, and standardization of vaccine are being vigorously attacked in order that nation-wide application of the Preventive Vaccination Law, with high quality diphtheria toxoid, may assure even better results.

Cholera

Investigations revealed that cholera has been reported in Japan at least since 1900. The incidence has been negligible since 1920. (Ref. tables 13, 14, 23, 24) However in the spring of 1946, after the repatriation program was underway, cholera did appear on repatriation ships from China and other Far Eastern countries.

Public Health and Welfare in Japan

Stringent quarantine control measures had previously been initiated and proved to be very effective in preventing cholera entering Japan through the repatriation program. In April 1946 two cases of cholera were reported from the southern island of Kyushu. Isolated outbreaks then began to occur throughout the area and were subsequently traced to illicit shipping and smuggling from Korea, where an epidemic was in progress. Cases continued to increase totaling 1,229 for the calendar year, most of which occurred during the months of July and August.

Stringent control measures consisting of isolation, quarantine, disinfection and focal immunizations were carried out in all areas where cholera appeared. These measures were initiated promptly and proved very effective in preventing large scale epidemics. As large areas of the population were immunized where ever cases occurred, particularly seaport cities, approximately 34,500,000 persons received cholera immunizations.

During the fall of 1946 the cholera rate declined rapidly. Only sporadic cases were reported during this period with the last case occurring in December. No cases have been reported since that time. Ample supplies of vaccine are maintained for emergency purposes, and quarantine staffs of both Military Government and Japanese prefectural health departments have been repeatedly cautioned to maintain a close watch for cholera suspects.

The Preventive Vaccination Law (1948) carries a provision for immunization or re-immunization against cholera in the event of a threatened epidemic.

This disease has been eradicated from Japan. No immunizations or active programs are indicated in the absence of reported cases. However, adequate stocks of vaccine will continue to be maintained for emergency use and quarantine personnel will continue to be orientated on necessary control measures in the event of the appearance of cholera.

Dysentery

Dysentery has always been prevalent in Japan. This is a filth-borne disease which cannot be eliminated or even satisfactorily controlled until standards of living, unsanitary customs and practices are improved. Medical science has not as yet provided a satisfactory immunizing vaccine, serum or drug capable of controlling this group of diseases. Control therefore lies chiefly in the education of the people in the matter of sanitation, personal hygiene, improvement of water supplies, waste disposal and the control of flies.

The dysentery incidence has always been extremely high with marked seasonal fluctuations during the year. The peak is always reached during the months of August and September with the low point in January or February. During the past 7 years the rates in August and September have ranged from 200/ to 400/100,000/annum while the low point in January and February has ranged from approximately 3/ to 15/100,000/annum.

Annual incidence rates have ranged from approximately 70/100,000/annum to 105/100,000/annum. Morbidity and mortality rates parallel each other closely. (Ref. chart 7 and tables 13, 14, 23, 24)

The poor economic status of the people, plus the complete lack of sanitary conditions as a result of the war and immediate post-war period, resulted in an actual increased incidence of this disease.

The dysentery control program involves the improvement of environmental sanitation, water supplies, waste disposal and the control of insects and rodents. Training programs for Japanese public health personnel have been continuously carried out and educational campaigns through the media of the press, radio, posters, schools and social organizations have been fostered. Sulfonamides were made available to physicians in addition to the providing of material and supplies for public sanitation programs.

While these measures did not materially affect the incidence rate during 1946, field inspections indicated that sanitary conditions were showing improvement and that a reduction in the dysentery incidence rate could be expected to follow.

The dysentery case rate during 1945 was 138/100,000/annum and during 1946 was 116.8/100,000/annum. During the succeeding two years of 1947 and 1948, marked reduction in rates to 50.5 and 18.3 respectively were accomplished. The 1938-1945 mean is 101.6/100,000/annum. The 1948 rate of 18.3 as compared with the 1945 rate of 138.0 shows an 87% reduction in the incidence of dysentery. The effectiveness of measures taken in the form of health education, insect control and environmental sanitation is reflected by the fact that the present rate is the lowest in the history of Japan. (Ref. chart 7 and tables 23, 24)

Future programs provide for a continuance of fly control, improvements of environmental sanitation, water supplies, waste disposal and a continuing education program for Japanese health officials and the general public concerning techniques to be used and the importance of such control measures.

Typhoid and Paratyphoid

Typhoid is also a filth-borne disease which has always been prevalent in Japan. Incidence rates since 1900 and prior to the occupation have varied from 40.5/100,000/annum (1903) to 100.1/100,000/annum (1924). (Ref. table 24) Since 1920 mortality rates have varied from 8.7 (1942) to 23.9 (1924) per 100,000/annum. (Ref. table 14) It is prevalent throughout the year, the highest incidence occurring in July, August and September. (Ref. charts 8, 9)

During the past seven years, the highest reported incidence occurred during the months of September and October 1945, due principally to the destruction and disruption of normal sanitary facilities during the latter part of the war. There was reported during the first year of the occupation, approximately 65,000 cases of typhoid

DYSENTERY: JAPAN, 1938-1948

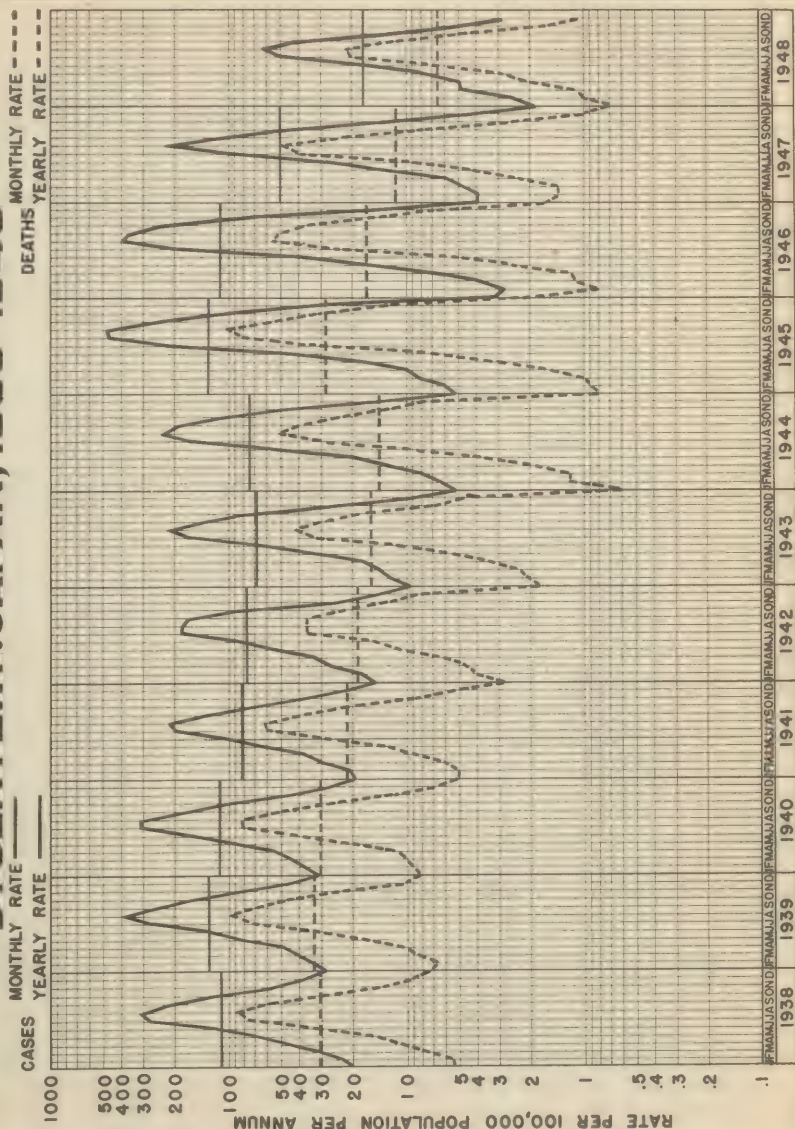


Chart 7

TYPHOID FEVER: JAPAN, 1938-1948

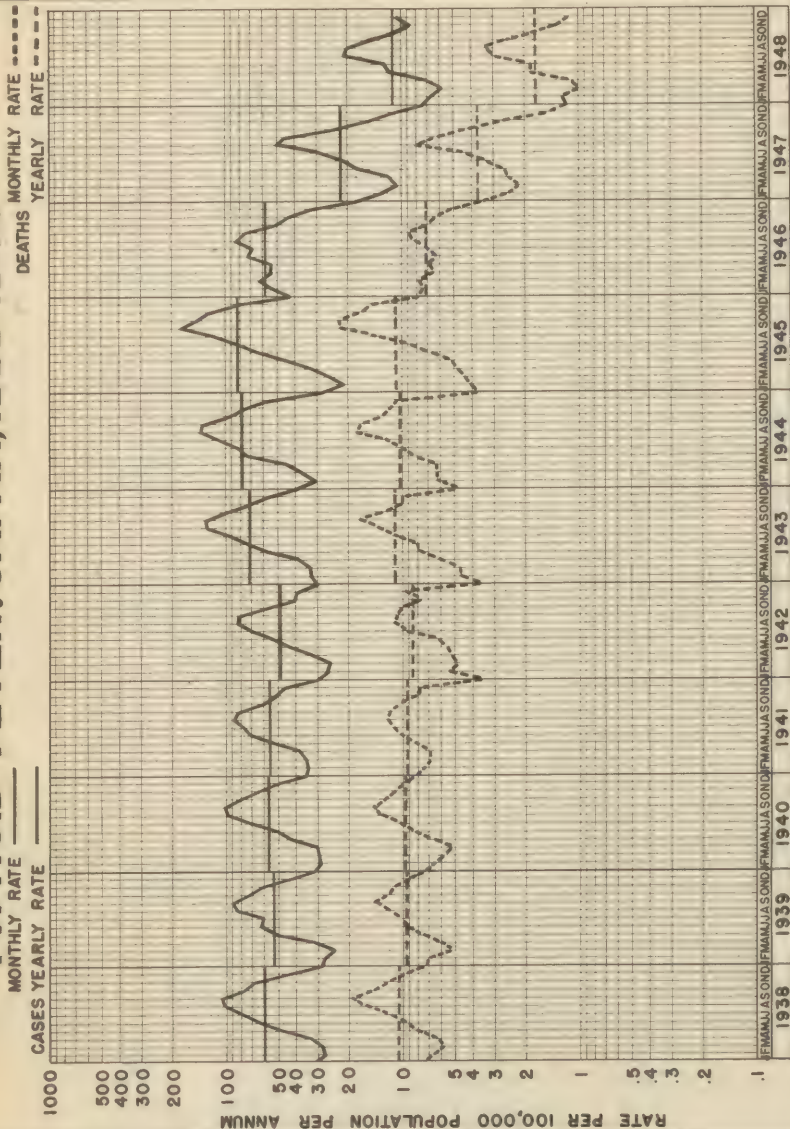


Chart 8

PARA TYPHOID FEVER: JAPAN, 1938-1948

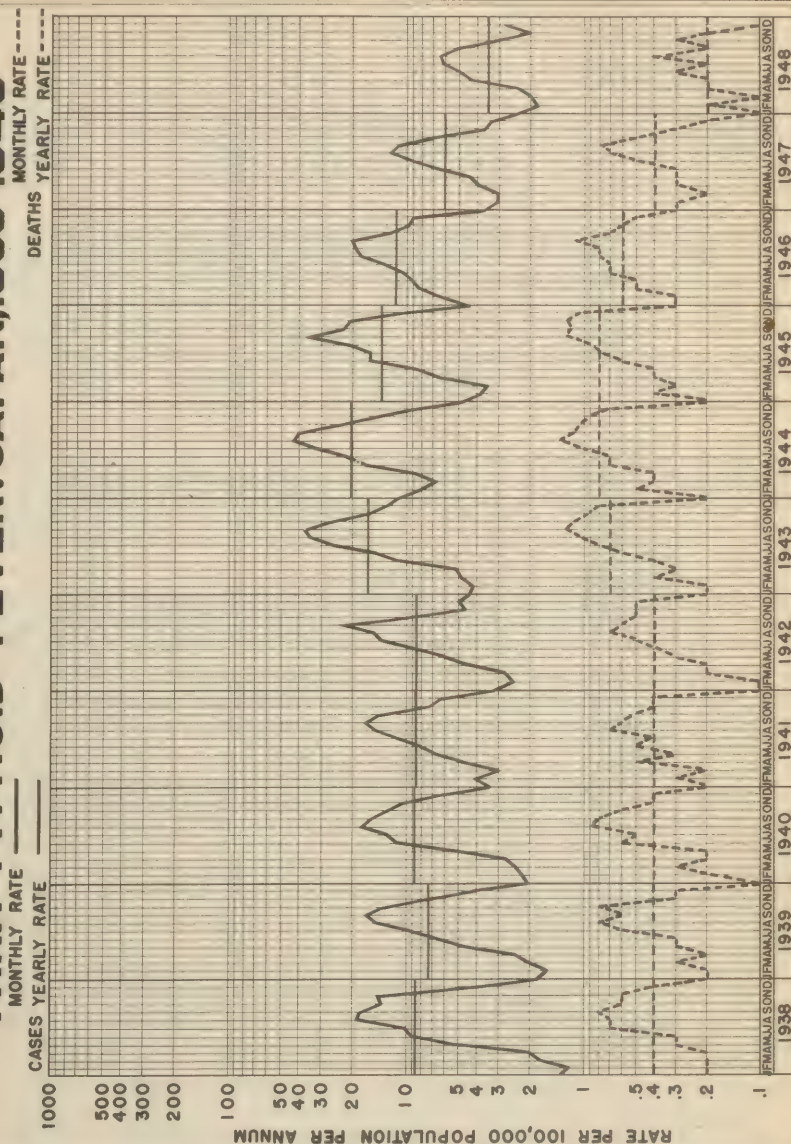


Chart 9

Public Health and Welfare in Japan

and 11,500 cases of paratyphoid fever. These figures represented a substantial increase over the previous twelve months.

Reports show that of the total number of cases and deaths occurring from typhoid during the first year of the occupation, 43% occurred during the first three months or before control measures could be established. This was the period in which the effects of the disruption of normal control measures were most noticeable.

Prompt action was taken to improve environmental sanitation. To effect immediate insect and rodent control, sanitary teams were established. The repair of war damaged municipal water systems, and the chlorination of public water supplies was begun. Waste collection facilities which had become almost non-functional during the war were reactivated and streets were cleared of garbage and rubble thereby eliminating extensive fly breeding areas. An immunization program was also inaugurated.

Since good vaccines are known to be effective against typhoid and paratyphoid it was expected that the incidence of these diseases would be reduced by these measures; however, due to the high incidence during the first three months of the occupation, the annual rates were adversely affected.

During 1946 approximately 20,000,000 persons received immunizations. The Japanese had never adopted standard procedures for the manufacture and assay of typhoid and paratyphoid vaccines and as was to be expected, the results obtained by immunization were not consistent. Even so, the sanitation and immunization programs carried out during this year led to a reduction of typhoid and paratyphoid fever cases.

Proof that typhoid and paratyphoid vaccine can be effective against these diseases resulted in plans for a nation-wide immunization program. In order to insure that this program would be completely successful, minimum standards for TAB vaccines were provided in addition to obtaining seed cultures successfully used by the United States Army. Difficulties encountered in production and assay were surmounted.

The program was launched in September 1947 and given full publicity. By the end of 1948 approximately 50,000,000 persons had received a full course of inoculations out of approximately 60,000,000 scheduled for immunization.

Control measures during the occupation have resulted in the typhoid-paratyphoid case rate being reduced to the lowest in Japanese history. During the occupation, it has been reduced from a high of 59.2/100,000 in 1946 to 11.8/100,000 in 1948, a reduction of approximately 80%.

The Preventive Vaccination Law (1948) requires routine immunization and re-immunization against typhoid and paratyphoid fever. Under this law, every person between the ages of 3 years and 60 years will receive an initial immunization, if not previously immunized, with initial immunizations thereafter for every child between the ages of 3 to 4 years after birth and, an annual re-immunization of 1 booster

shot for all others between 4 and 60 years of age.

The nationwide immunization program calls for approximately 60,000,000 people to receive immunizations annually. This will consist of about 2,000,000 initial immunizations to children and approximately 58,000,000 booster doses to others. Booster doses will be given on or about 1 May of each year to those who have previously completed a full course of inoculations.

Long range plans have been drawn up for the continuance and improvement of sanitation programs. These control measures will further reduce typhoid and paratyphoid fever to levels comparable to other modern nations.

Malaria

Malaria has been endemic in certain areas in Japan for many years but its extent was not known as it was not a reportable disease until June of 1946.

For 1947 the reported incidence was 15.2/100,000/annum and for 1948, 6.2/100,000/annum. These rates include primary and recurring cases. (Ref. tables 23, 24, 25, 26)

The great majority of cases were recurrences occurring in demobilized military personnel repatriated from the Southwest Pacific area and the Asiatic mainland. There was also considerable malaria in civilian repatriates from China, Manchuria and Southeast Asia. As repatriation from these areas ceased, the reported cases became more noticeably centered in endemic foci of infection principally in Shiga Prefecture, from which 2258 of the 4940 cases for Japan in 1948 were reported.

Routine insect and rodent control carried out by sanitary teams was designed to prevent the spread of malaria from repatriates returning from malarious areas. Adequate supplies of insecticides and larvacides were provided and special malaria control training courses were established.

There has been a progressive decline in the number of cases reported since near completion of repatriation from the above-named repatriation areas and also a decrease in the number of recurrences in infected repatriates.

The control program has been remarkably effective and at the present time only one small area located in Shiga Prefecture remains as an important foci. Control measures concentrated in this area are expected to eliminate this foci also. (Ref. tables 23, 24, 25, 26)

The main emphasis in future programs will be directed toward the control of vectors through intensive mosquito control programs with particular emphasis upon the remaining endemic foci, together with adequate treatment of cases and the education of the general public.

Japanese B Encephalitis

Japanese B Encephalitis has been present in Japan for many years with occasional epidemics in the past. The last two major outbreaks prior to the Occupation occurred in 1924 and 1935. The disease was made reportable in June 1946. During the last half of 1946, the incidence of reported cases (259), practically all of which occurred during the last six months of the year, was nearly twice that of the latter half of 1946, with the rate for the entire year 0.3/100,000/annum. Most reported cases were not confirmed by laboratory examinations. The prefecture with highest reported incidence was Okayama.

The summer of 1948 was marked by an epidemic which exceeded, in extent and number of cases reported, both the 1924 and 1935 epidemics. Although a few scattered suspect cases occurred earlier in the summer, the epidemic proper began in Tokyo on 21 July and spread rapidly during the ensuing weeks first to prefectures neighboring Tokyo and then to all parts of Japan. There were altogether 7208 cases and 2621 deaths reported for the year; of this number 1969 cases with 527 deaths were reported from Tokyo. The peak of the epidemic was reached at the end of the third week in Tokyo and in the fourth week for Japan as a whole, with rapid subsidence from the 5th to 8th weeks. The highest age incidence was in the 5 to 9 year age group. Prefecture case rates were higher in Central and Northern Honshu than in the endemic area about the Inland Sea (Ref. tables 13, 14, 23, 24, 25, 26)

Studies designed to evaluate the effectiveness of Japanese B Encephalitis vaccine among the Japanese people were undertaken during each of the early summer months of 1946, 1947 and 1948 in Okayama Prefecture. During the period of these studies, there were too few cases to draw any valid conclusions. However, only one case (non-fatal) has been recorded to date among those vaccinated.

Special studies to determine anti-body levels in groups of vaccinated and unvaccinated children were underway when the 1948 epidemic supervened. Additional studies were made possible by the occurrence of the epidemic and these are continuing.

Intensified insect control measures taken during the epidemic did not appear to affect its course.

Further studies on the relative effectiveness of immunization and exposure are being continued. Earlier and more effective insect control is planned to reduce the chances of recurrence of the outbreak.

Scarlet Fever

Scarlet Fever has existed in Japan at least since 1897 when it was made a reportable disease. Available records since 1900 indicate that 1939 was the peak year when the rate was 28.3/100,000/annum. In 1946 the incidence was 2.9/100,000/annum and although the rate rose to 3.4 during 1947 and 3.7 during 1948, no serious epidemics have occurred. (Ref. tables 13, 14, 23, 24)

Public Health and Welfare in Japan

The incidence of scarlet fever has remained at a relatively low level and, as it has not constituted a serious public health hazard at any time during the Occupation, no specific action or program has been attempted other than to maintain sound practices of diagnosis, isolation and treatment of cases and observation of families and contacts. (Ref. chart 10)

It is expected that the application of isolation procedures and the use of penicillin and/or sulfonamide as treatment will serve not only to reduce the death rate but will also shorten the period of infectiousness and aid in the reduction of morbidity.

Epidemic Meningitis

Epidemic meningitis, a reportable disease in Japan since 1918, has remained at a consistently low level during the entire period.

Prior to the Occupation, the highest incidence recorded was in 1919, when it was 4.4/100,000/annum, and although the rate rose to 6.3/100,000/annum in 1945, it has again dropped to its pre-war level and for the past twelve months has remained at 2.6/100,000/annum. (Ref. chart 11 and tables 23, 24)

The disease has not constituted a serious public health hazard since the Occupation; therefore, no specific action has been taken other than to adopt suitable diagnostic, therapeutic and isolation techniques and observation of families and contact.

It is planned to use penicillin and/or sulfonamide in the treatment of epidemic meningitis cases which is expected to decrease the death rate and shorten the period of infectiousness, thus aiding in the reduction of morbidity. Current improvement in hospital care is also expected to lower the disease incidence.

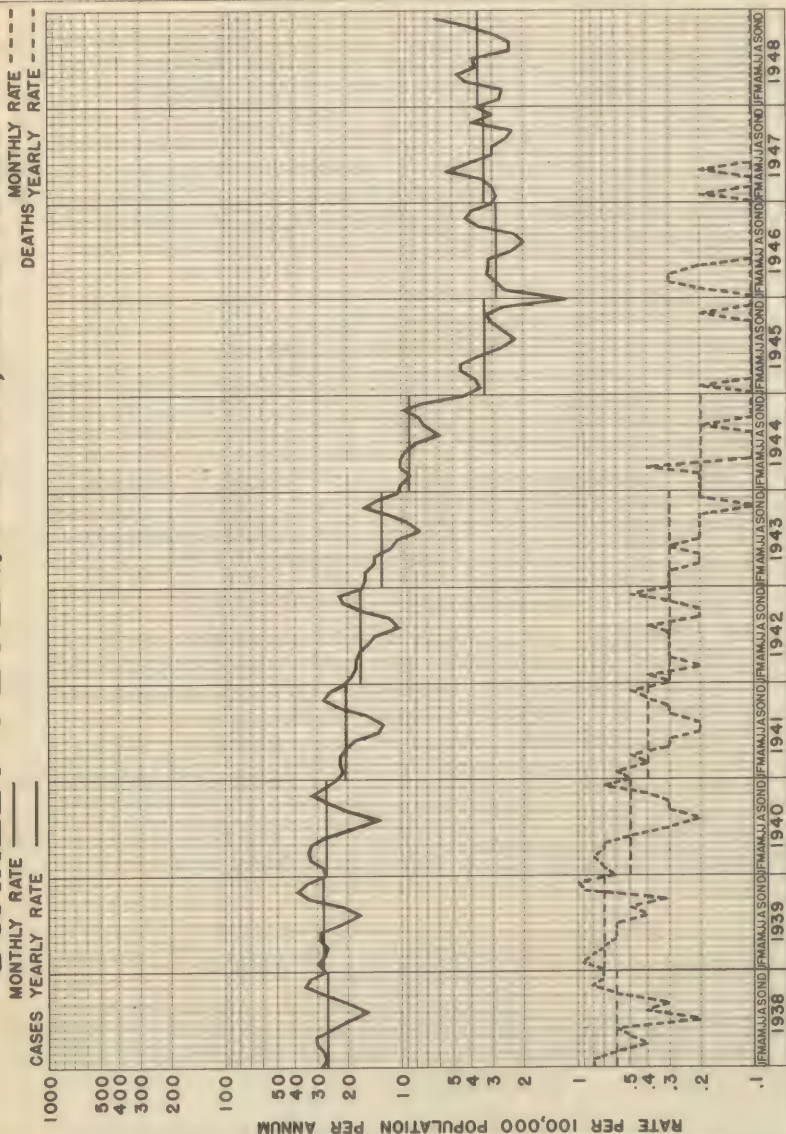
Pertussis

Pertussis is prevalent throughout Japan and is a leading cause of death among infants and young children. It was made a reportable disease in March 1947, although deaths have been reported since 1920. During 1948, a total of 52,789 cases were reported, with a case rate of 66.2/100,000/annum and a death rate of 6.0/100,000/annum. (Ref. tables 13, 14)

Due to the necessity of directing major efforts toward control of the diseases which were a more serious health hazard, no action was taken to initiate a program for reducing the incidence of pertussis until the summer of 1947. Improved standards for the production and assay of pertussis vaccine have been encouraged and plans for the vaccination of all infants and small children have been completed.

Under the provisions of the Preventive Vaccination Law (1948)

SCARLET FEVER: JAPAN, 1938-1948



(10) PHARM/HS CHART NO. 845 24 2 449

Chart 10

EPIDEMIC MENINGITIS: JAPAN, 1938-1948

MONTHLY RATE _____
 CASES YEARLY RATE _____
 MONTHLY RATE -----
 DEATHS YEARLY RATE -----

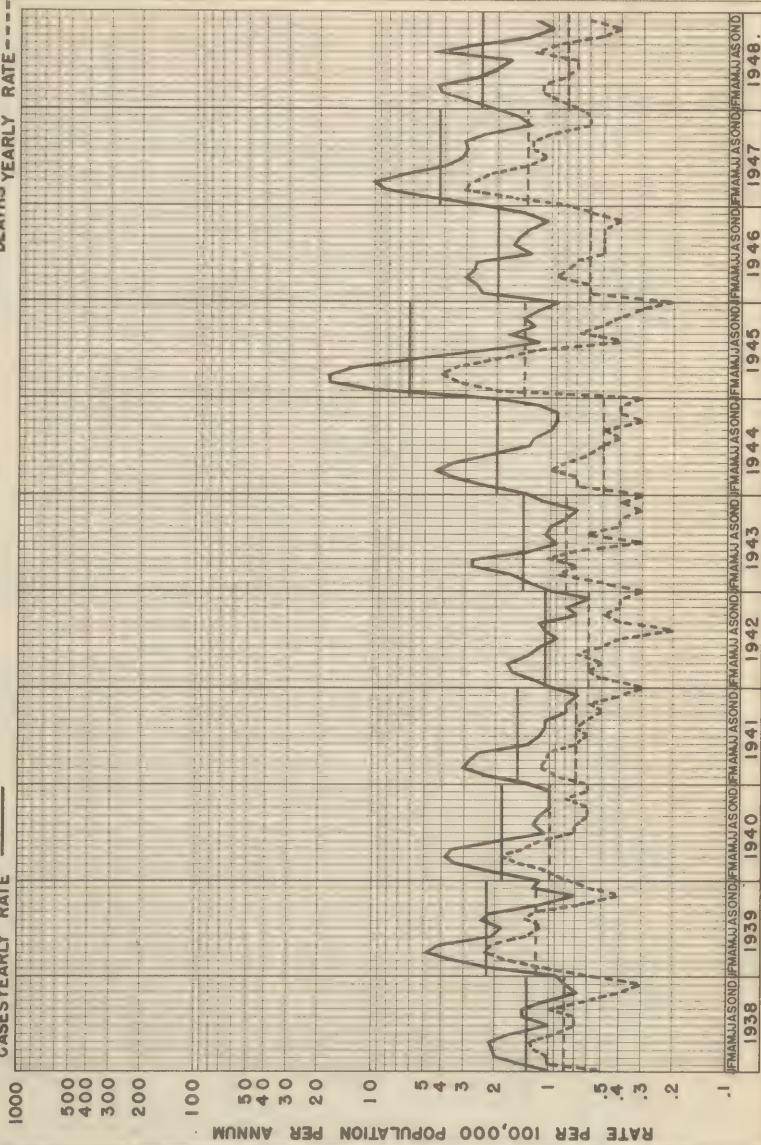


Chart 11

immunization of all infants against pertussis will become compulsory by 30 June 1949. The law provides for the immunization of all infants between the ages of 3 and 6 months and re-immunization with a booster dose, 12 to 18 months after the initial immunization. The deferment of full enforcement of the law until 30 June 1949 was necessary because facilities were not adequate for immediately producing and assaying the required amounts of vaccine. However, production is increasing and immunization of all infants and small children is continuing as rapidly as vaccine is produced and assayed.

Future plans provide for production of sufficient good quality vaccine to carry out the planned immunization program on all infants and small children in accordance with the Preventive Vaccination Law. This program, plus general health education is expected to reduce the current disease rate.

Tuberculosis

Tuberculosis, for many years the leading cause of death in Japan, has been extremely prevalent as far back as records concerning it are available. Deaths have been reported since 1900 - however, cases were not reported prior to the Occupation since tuberculosis had not been designated as a reportable disease.

Tuberculosis morbidity statistics under the best of conditions are considered to be of relatively little value, consequently, in the past, investigators of tuberculosis in all countries have, of necessity, had to rely upon mortality statistics in order to obtain comparative results.

At the beginning of this century, the death rate from tuberculosis as reported in Japan was 160/100,000/annum. This compared very favorably with the rate in the western nations at that time. However, Japan was just then beginning to feel the effects of the industrial revolution which probably had much to do with the high rate in the western nations. From that time on, the rate in Japan gradually increased until 1918 when it was recorded at 253/100,000/annum. A gradual decline followed until 1932 when the rate was recorded as 179.5/100,000/annum. After that there was another gradual increase and in 1945, at the time of the arrival of the Occupational Forces, the rate (estimated) was 280/100,000/annum although figures for deaths by age groups were not available due to loss of records by fire during the war. (Ref. chart 12 and tables 13, 14, 20, 21)

Tuberculosis has been the leading cause of death in Japan since 1934. (Ref. chart A-5 and tables 15, 16, 17) Previously diarrhea and enteritis had occupied the leading positions and pneumonia was next. As deaths from these causes declined tuberculosis assumed the lead. It accounted for from 12% to 14% of the deaths from all causes. As it was considered a shameful disease, to be concealed whenever possible, very few cases were brought to the attention of public health authorities.

The serious economic conditions, shortage of food, fuel and

COMPARATIVE TUBERCULOSIS DEATH RATES:1900-1948

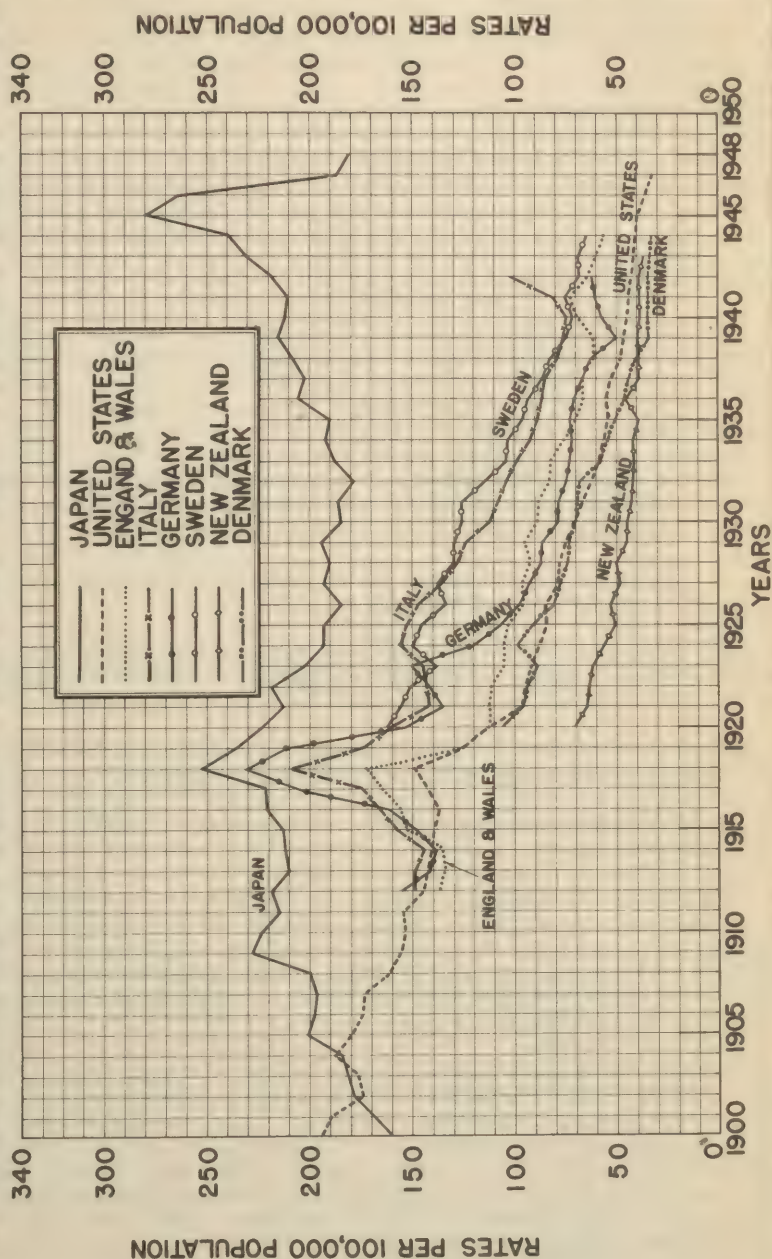


Chart 12

clothing and the overcrowding and unsanitary conditions during the last years of the war contributed materially to the continued and increasing prevalence of this disease. In 1945 tuberculosis sanatoria were found to be only 25% occupied due, mainly, to active cases leaving these institutions in search of food. These cases were therefore acting as sources of additional infection.

The Japanese had been conducting research on BCG since 1927 and in 1943 the National Research Council had evaluated the progress made up to that time and concluded that the use of BCG vaccine should be encouraged as a means of tuberculosis control. Some of the BCG vaccine used was of questionable potency due to lack of standardized procedures for production and assay.

Tuberculosis control did not receive priority during the first year of the Occupation because of the urgency of establishing health control measures for the more acute communicable diseases. In October 1946, however, an active control program was inaugurated, the immediate objectives consisting of:

1. To encourage the return of active cases of pulmonary tuberculosis to hospitals by providing food and other necessary supplies thereby enabling hospitals to care for these patients.
2. Emphasis upon education of the medical and nursing professions in diagnosis and medical care.
3. Inauguration of a school lunch program for supplemental feeding of school children in order to provide a more balanced diet and increased resistance to infection.
4. Mass examination of school children together with individual case finding, tuberculin testing and BCG immunizations.
5. Mass examination of workers in factories and other industrial organizations.

Full publicity was given this program through all available media of information such as radio, press, posters, lay and professional journals and magazines. Many prefectures organized Tuberculosis Care Committees to assist patients in entering sanatoria, maintaining their families during hospitalization and obtaining suitable occupations upon their return from the sanatoria.

Significant results were soon noticeable. Through increased government rations to hospitals and institutions, augmented by voluntary contributions through LARA, (Licensed Agency for Relief in Asia) the food situation has improved and all prefectures are now receiving increased rations for tuberculosis patients. A school lunch program which was successfully inaugurated in 1947 has been expanded until it now serves approximately 6,500,000 children. (Ref. Chapter 6, WELFARE, The School Lunch Program)

Necessary X-ray equipment was provided through the repair of old units and manufacture of new equipment. Sufficient X-ray film to meet minimum requirements was also produced in Japan.

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Case reporting was required beginning in January 1947. This was the first time that tuberculosis cases had ever been routinely reported in Japan. These reports indicate that approximately 380,000 new cases of tuberculosis are being diagnosed each year.

The nation-wide examination program for the detection and control of tuberculosis has been closely supervised. Mass examinations have taken place in factories, schools and other organizations. Approximately 31 million BCG vaccinations have been given since 1943, most of which, under the supervision of the Ministry of Welfare, were given to the 10-24 year age groups.

Education of the medical and nursing profession as well as those individuals having active cases has resulted in an increased hospital occupancy. Of some sixty thousand beds now available, more than fifty thousand are occupied. Beds of national sanatoria are more than 90% occupied.

The control program has resulted in a reduction of the death rate from 280/100,000/annum (estimated) at the beginning of the Occupation to 181.1/100,000/annum in 1948. It is significant that most of the actual reduction has occurred in the BCG vaccinated groups thus confirming the value of BCG in the control of tuberculosis. (Ref. chart 13 and tables 20, 21)

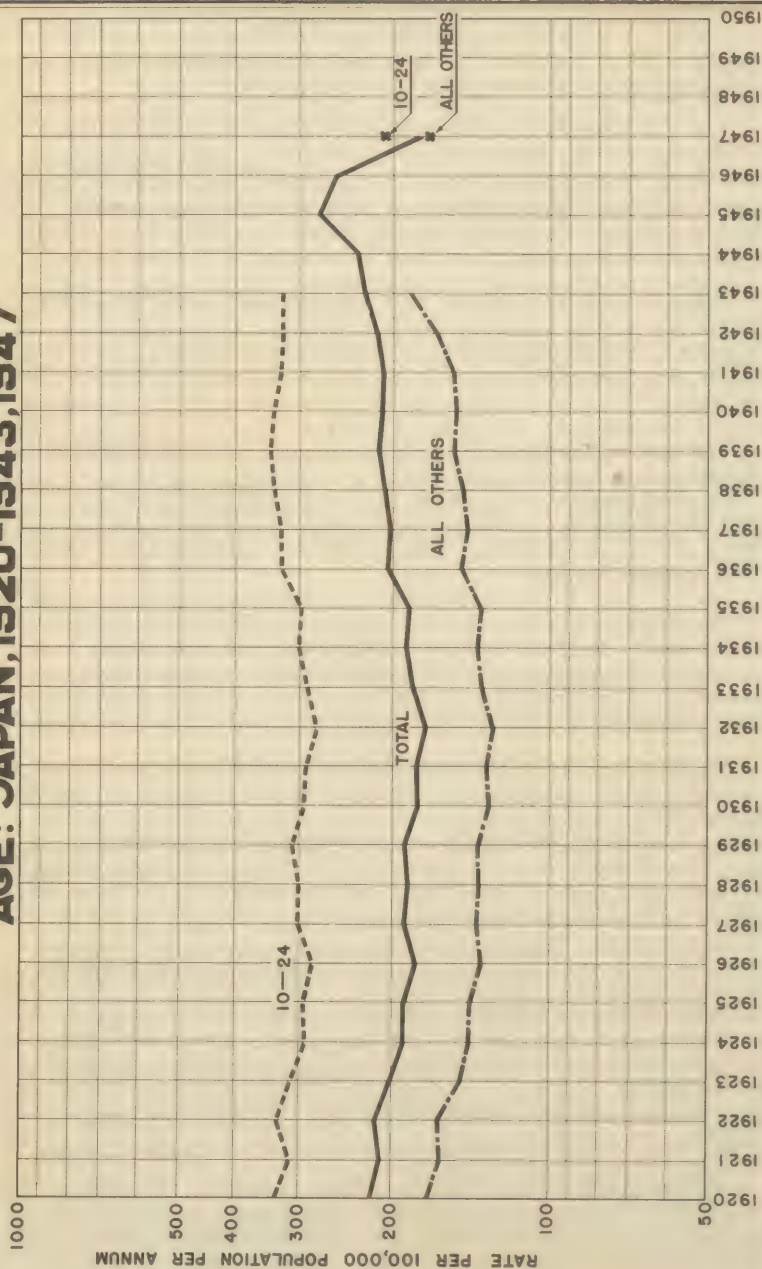
Included in the Preventive Vaccination Law are compulsory provisions which become effective 1 July 1949, for the yearly vaccination with BCG of all individuals between the ages of six months and thirty years who are tuberculin negative and show no clinical signs of tuberculosis or other contra indications.

Implementation of this law will ultimately result in history's first tuberculin positive population. In the early years of this program, over half of the population will be tuberculin positive because of natural infection, but as the years pass the proportion artificially positive will increase. As this proportion increases, the "effective contact rate" will decrease and will in time reach a level at which clinical tuberculosis will no longer be a problem to Japanese society.

In order to implement this plan, the production of dried BCG vaccine is being undertaken. This is considered necessary because the potency period of the wet vaccine is only about seven days. Poor transportation and refrigeration facilities have been important factors resulting in the use of vaccine of questionable potency. Furthermore, the use of dried vaccine will permit adequate assay before distribution.

In the past, most efforts have been concerned with the various technical problems of diagnosis and treatment. In the future, however, more emphasis will be placed on the administration aspects of tuberculosis control. The broader fields of case supervision which have heretofore been neglected will be emphasized. Tuberculosis control officials are now being indoctrinated with the concept that their function involves coordination of all phases of public health since it is only by integration of the preventive, medical care, welfare, and social security aspects of public health that a successful tuber-

DEATH RATES FROM TUBERCULOSIS ACCORDING TO AGE: JAPAN, 1920-1943, 1947



culosis control program can be carried out.

Streptomycin therapy for tuberculosis will be introduced into Japan early in 1949. A culture of Streptomycin griseus obtained from Rutgers University has already been turned over to officials of the National Institute of Health for further development preparatory to inauguration of commercial production by Japanese antibiotic manufacturers. It is anticipated that by the end of 1949 production will meet minimum demands for the treatment of tuberculosis. A large quantity of streptomycin is scheduled for import as a temporary measure until commercial production is firmly established. This will be distributed through the Ministry of Welfare for use in hospitals having suitable personnel and facilities for the treatment of tuberculosis. Due to the present lack of bodily resistance of the Japanese people, their poor economic status and lack of adequate sanatoria care the use of streptomycin will be urged in all early cases.

Additional tuberculosis beds will be made available insofar as is possible under the existing economic conditions. Present plans call for doubling the number of beds available in national institutions during the next fiscal year. This would result in an overall bed/death ratio of about .75. The present over-all ratio (public and private) is .416.

Venereal Disease

Preliminary studies and observations of the venereal disease problem at the beginning of the Occupation revealed the following facts:

1. Venereal diseases were considered as diseases of prostitutes, primarily, and for this reason they were not a cause for concern either by the Japanese physicians, public health authorities or the general public.

2. Japanese physicians, with very few exceptions, were unfamiliar with the epidemiologic and clinical manifestations of venereal diseases.

3. Control methods were almost entirely devoted to the periodic examination of prostitutes and such examinations as were made were perfunctory and practically worthless.

4. No provisions existed for the care of infected persons in the general population.

5. Such clinical procedures as were in effect were archaic; laboratory procedures were poor and totally inadequate.

6. Contact tracing and case holding were not carried out.

7. Venereal diseases were not reportable and there were no reliable statistics or other data available from which a reliable estimate of the incidence of the venereal diseases could be made.

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8. Licensed prostitution was legal and flourished both in brothels and on the streets, so that the opportunity for the spread of venereal disease was practically unlimited.

9. Segregation of prostitutes into prostitute districts, which was said to be strict before the war, had broken down during the war.

10. Permits to work as prostitutes were formerly under police supervision but this also became lax during the war.

Faced with the realization that the venereal diseases posed a serious problem for the Occupation Forces, the Japanese Government was directed in October 1945 to:

1. Designate syphilis, gonorrhea and chancroid as infectious diseases.

2. Report all syphilis, gonorrhea and chancroid on a basis similar to that in effect for reporting other notifiable diseases.

3. Rigidly enforce laws for the prevention of infectious diseases and all laws, ordinances, regulations and instructions issued thereunder which relate directly or indirectly, to the prevention and treatment of venereal diseases.

4. Bring under examination and treatment as provided in these laws, ordinances, regulations and instructions, all individuals whose occupation or activities subject them to serious hazard of venereal disease transmission.

5. Provide hospital beds, clinic and laboratory facilities, the personnel, equipment and drugs necessary to insure required examinations, isolation, hospitalization and treatment.

6. Establish minimum technical and administrative standards and procedures for the guidance of operating agencies in connection with all phases of this program.

In a subsequent instruction dated 21 January 1946, the Japanese Government was directed to abrogate and annul all laws, ordinances and other enactments which directly or indirectly authorized or permitted the existence of licensed prostitution in Japan, and to nullify all contracts and agreements which had for their object the binding or committing, directly or indirectly, of any woman into the practice of prostitution.

Continuous efforts have been made to improve professional techniques, to provide improved hospital and clinic facilities for venereal disease patients and to educate both the medical profession and the general population in the medical aspects of these diseases.

Treatment facilities for the general population have been established in many national, prefectural and municipal hospitals, health centers and clinics. Treatment schedules have been furnished, and clinical and epidemiologic procedures have been demonstrated.

A manual on the principles of venereal disease control has been

Public Health and Welfare in Japan

prepared and translated into Japanese and distributed.

Adequate quantities of effective drugs such as the sulfonamides, mapharsen, bismuth sub-salicylate and penicillin are being produced indigenously in Japan. With the exception of sulfonamides none of these were produced in Japan prior to the Occupation. Action has also been taken to supply adequate food to hospitals treating venereal diseases in order to insure the retention of venereal disease patients as long as necessary.

Japanese prefectural venereal disease control personnel have been designated in each prefecture and under the supervision of Military Government health officers have been directed to place special emphasis upon venereal disease control in the general population.

Special lectures and training in venereal disease control is now included in full time and short refresher courses for doctors, public health nurses, internes and medical students.

The over-all program has been given wide publicity and in conjunction with the Civil Information and Education Section of SCAP, information is being disseminated over the radio, through the press, magazines, journals and by poster displays to the general public.

The Health Center Law (Law 101, 5 September 1947) provides for a venereal disease control service in each of the 800 health centers throughout Japan. Currently, there are 406 venereal disease clinics in the 675 existing health centers. During the model health center demonstration held in Tokyo in March and April 1948, a model health center venereal disease control service was demonstrated for the guidance of both Military Government and Japanese prefectural health officers. Besides the operation of a clinic, such other functions as contact-tracing, case-holding, routine serological tests, mass blood-testing and public education were stressed. In this way, uniform operating procedures were encouraged.

In addition to the venereal disease clinics in the health centers, there are approximately 424 other diagnostic and treatment clinics in operation.

The Ministry of Welfare is supporting the venereal disease program and is providing leadership, funds and facilities for its support and expansion. For example, some patients found the cost of medical care prohibitive and in order to meet this situation a plan was developed whereby the national and prefectural governments share equally the cost of treatment for those individuals thereby assuring prompt and complete medical attention for medically indigent venereal disease cases.

A Venereal Disease Prevention Law was passed by the Diet on 3 July 1948 and became effective 1 September 1948. This law provides for pre-marital examination for venereal disease, a pre-natal examination for venereal disease, and compulsory examination of all venereal disease contacts and suspects. Civil rights are safeguarded in the case of all compulsory examination by provisions for appeal to a court by the individual, if he or she claims there is not reasonable evidence to suspect the presence of venereal disease. The Law further

provides for free treatment of all venereal disease patients who are unable to pay for such services.

Reporting of the venereal diseases was initiated in December 1945. During 1946 the case rates for gonorrhea, syphilis and chancroid were 171.6, 99.4 and 41.2/100,000/annum respectively. There was noticeable improvement in reporting as the year progressed, and although reporting by private physicians is not yet entirely satisfactory, definite progress has been made in arousing the interest of both physicians and the general public in the over-all control program. During 1947 the case rate for gonorrhea was 271.4/100,000/annum and during 1948 it was 273.2/100,000/annum. However, during the same period the case rates for syphilis increased from 189.0/100,000/annum to 269.0/100,000/annum, while the incidence of chancroid decreased from a case rate of 51.9/100,000/annum in 1947 to 45.7 in 1948. (Ref. chart 14).

The marked proportionate increase in reported syphilis as compared to gonorrhea is believed to be due to several factors:

1. The availability and use of sulfonamides in the treatment of gonorrhea may have decreased the over-all incidence of that disease, or at least prevented an increase in reported cases.
2. The greater number of serologic examinations for syphilis now performed, in accordance with law, which tend to bring out latent and otherwise unrecognized cases of syphilis.
3. The tendency to accept a single positive serological test as diagnostic for syphilis without adequate clinical and serological confirmation.
4. The relative difficulty in making a diagnosis of gonorrhea due in part to the free use of sulfonamides and penicillin.

Future plans provide for the establishment of satisfactory diagnostic and treatment facilities in every health center in Japan. Efforts will be directed toward continuance, expansion and improvement of the present program with special emphasis on education together with improved contact tracing, case-holding and reporting procedures.

Reduction in Death Rates

The over-all success of the various communicable disease control programs is demonstrated by the fact that the mean crude death rate for 1948 was 12.0 per 1,000 population as against 14.6 per 1,000 population for 1947, 17.6 for 1946 and 29.2 for 1945. The 1948 rate is 18% less than 1947 and 59% less than 1945.

VENEREAL DISEASES-JAPAN

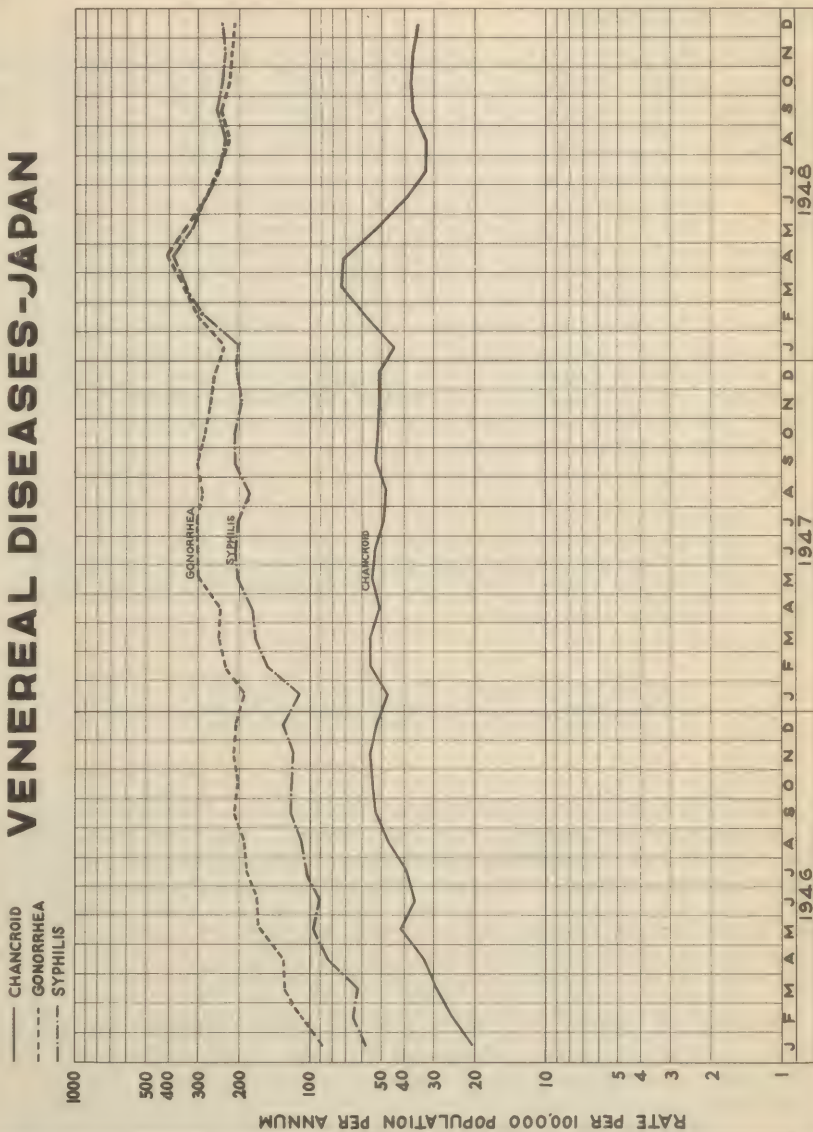


Chart 14

Public Health Statistics

The family registration system (Koseki), the basis for statistics of births, deaths, marriages and divorces, has a very old history. An Imperial edict issued at the time of the Reformation of the Taika era in 645 AD was the first enactment on the Koseki system in Japan. It was modelled after the Chinese system, where the Koseki system is believed to have originated. There are historical references to the Koseki in Japan as early as 209 AD, but scholars consider it unlikely that the system existed prior to the sixth century. When the clan system was still in effect, the family name was recorded in the Koseki to fix the status of the clan. In the early days the Koseki records formed the basis for allotting land, the collection of taxes, and the detection of vagrants and criminals. Health conditions of the people were recorded in the Koseki record in some detail, describing deformities and disabling diseases. This information was used in levying labor. Some of the purposes for keeping the Koseki records have changed. Others have continued to the present such as family relationship, identity, inheritance, etc.

In addition to a review of activities in the field of public health statistics during the period 1945-1948, a comprehensive analysis of vital statistics will be found in the attached annex. This analytical report includes detailed tables and charts on current and historical data in the fields of demography, natality, mortality, morbidity, marriage and divorces.

Development of Public Health Statistics

Although the family registration system was continued during the war, there were frequent interruptions and delays. Many of the original records were destroyed by fire and bombing. For many years before the war partial transcripts of information contained on the registrations of births, deaths, marriages and divorces were the basis for the national vital statistics. For statistics of stillbirths, because the registration of stillbirths was not required, data were obtained from medical certifications filed in local health offices in compliance with regulations on the issuance of permits to dispose of the fetus.

Transcripts used to be prepared in the local registration (Koseki) offices, located in places claimed as the ancestral family seat (place of Honseki). Transportation and communications facilities became so badly damaged in the war that this practice was discontinued in May 1944. A simple numeric monthly count of the vital events, made at the place in which the event was originally registered, was substituted for that formerly made in the place of Honseki. It was sent to the Cabinet Bureau of Statistics, which was the Bureau of the Census where national tabulations were made. These reports were frequently long delayed and incomplete. No annual report of National Vital Statistics had been published since 1943. There never had been any current publications.

Like the vital statistics, reports of morbidity were also long delayed and often incomplete. Ten diseases, usually referred to as the

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"legal diseases," were required to be reported every 10 days. They included diphtheria, dysentery, typhoid fever, paratyphoid fever, smallpox, typhus fever, scarlet fever, epidemic meningitis, cholera and plague. Monthly reports of morbidity were also required but were not being completed by the prefectures. Annual reports had not been published by the Ministry of Welfare since publication of the report for 1942. Even if the reporting systems both for morbidity and vital statistics had functioned, the information which they provided was inadequate to meet the requirements of a modern public health program.

A directive was issued on 22 September 1945 to the Japanese Government under the subject "Public Health Measures," which directed that a survey be made of the prevalence of disease, that weekly reports of communicable diseases be started immediately by prefecture, and that the reporting and analysis of vital statistics be expedited in accordance with policies established by SCAP. On 6 October 1945 the Japanese Government was directed to preserve all vital statistics records, to prepare such additional records as might be prescribed and to prepare reports of communicable diseases requested. On 16 October the government was further directed to report syphilis, gonorrhea and chancroid on a basis similar to that in effect for reporting other notifiable infectious diseases.

A survey of the current vital statistics situation was begun in February 1946 as a basis for future action. On 14 March the Japanese Government was required to prepare a plan for the collection of current vital statistics, which would provide, as a minimum, the total number of deaths, infant deaths, number of births and stillbirths by sex, and also the number of marriages and divorces. Further, it required these data be tabulated by prefectures and cities according to place of residence and submitted to SCAP not later than two months after the end of the month to which the report referred. All registrations were to be made in the actual place of residence.

A submitted plan, approved 12 April, was implemented by a directive requiring that immediate steps be taken to put the program in operation, and to proceed with such changes in the administration of the statistical organization as would be necessary to promote an efficient reporting system.

Practical operating considerations required a subsequent revision in the program. The Japanese Government was therefore directed on 15 June to make the necessary changes to provide for the registration of births, deaths, marriages and divorces in the place in which the event occurred, instead of the place of residence. Administrative controls to determine and insure the completeness of registrations could be successfully maintained only if these changes were made. (Ref. charts A-29 and A-33).

Beginning 1 July 1946 the system for obtaining monthly numerical reports of births, deaths, stillbirths, marriages and divorces was placed in operation. The numbers of events reported were based upon counts of original registrations made in local registration offices. In the past, these registrations were made primarily to comply with civil regulations and little use was made of them for public health purposes.

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Originally the program provided for the collection of vital statistics from transcript forms beginning 1 January 1947. Transcript forms used during the war were completely revised. Uniform, printed standard registrations forms for birth, death, marriage and divorce had never been used in Japan. Registrations were usually made through the use of public letter writers who prepared a statement of the facts required by law, or they were made verbally to the registration official who recorded them. Consequently, it was necessary to design, print and distribute four new registration forms, and to revise the laws concerning registration practices. Progress made in the recovery and development of vital statistics was more rapid than anticipated, as both the registration and transcript forms were completed and available for use before the prearranged date. On 28 August 1946 the Japanese Government was directed to amend the plan for collecting current vital statistics and to provide all local government offices not later than 1 October 1946 with standard printed forms for use in making the registrations and medical certifications. (Ref. charts A-24 - A-28).

Previous to 1 October 1946, when a person died it was the practice for a member of the household to secure two copies of the medical certification from the attending physician. There was no standard form and the physician wrote the certification on whatever paper he chose. One copy was filed in the local health office prior to receiving the cremation or burial permit, and the other was filed with the statement of personal particulars in the local registration office. The new registration form of death consists of one piece of paper containing the personal particulars in the upper part and the medical certification in the lower. The latter may be used either as a regular medical certification or as the certification of a medical examiner.

Laws concerning stillbirths were revised and the responsibility held jointly by the Home Ministry and the Ministry of Welfare was transferred entirely to the latter. The old procedure, so far as the medical certification was concerned, was the same as that followed for deaths, excepting that only one copy was prepared, and it was filed in the local health department in order to obtain the permit to dispose of the fetus. No registration of the stillbirths was made. Previously, transcripts of stillbirths were filled out from data contained on the medical certificate. The new stillbirth registration form is designed as one form, containing both the personal particulars and medical certification. Registrations of stillbirths are made in the local health offices because there is no provision to register them under the family registration system, and officials in charge declined to accept them. Uniform, printed stillbirth registration forms were distributed to all local health offices for use beginning 1 November 1946.

In October 1946 an Investigations Section was organized in the Ministry of Welfare. Included among its responsibilities were legal planning, public parks and preparation of the annual report of the Ministry. The latter involved the collection of a limited amount of statistical information. On 7 August 1947 a Public Health Statistics Section was established in the Ministry of Welfare and made responsible for morbidity and other public health statistics exclusive of vital statistics. In September 1947 the Section was additionally made responsible for vital statistics resulting in the transfer of vital statistics from the Cabinet Bureau of Statistics. This was in accordance

with previous directives issued to the Japanese Government, which recognized the fact that vital statistics is a public health measure which should be the responsibility of the Ministry of Welfare.

Effective 1 October 1947 vital statistics responsibilities of the prefectural statistics offices were officially transferred to the prefectural health departments. By November health statistics offices were in operation in every prefecture.

In December 1947 a medical certificate was added to the live birth registration form, to become effective 1 January 1948, by joint agreement between the Ministry of Welfare and the Office of the Attorney General (formerly named the Ministry of Justice). This marked the first time a medical certificate of live birth had ever been used. A question was added to the birth registration form asking whether the mother had a prenatal blood test.

Further improvements were made and instructions were issued by the Ministry of Welfare to establish public health statistics offices in each of the planned 300 health centers. The National Family Registration Laws (Koseki-Ho) and the Civil Laws, which were revised the latter part of 1947, became effective 1 January 1948, bringing them into conformity with the provisions of the new Constitution. Declaration forms of birth, death, marriage and divorce were revised to meet the requirements of the revised civil and family registration laws and placed in use 1 January 1948.

Prior to 1 January 1948 transcripts of birth, death, stillbirth, marriage and divorce registrations had never been routed from local registration offices, where they are prepared, through any of the health centers (and only a few of the prefectural health departments during the last two or three months of 1947) on their way to the national office. Beginning in January 1948, all transcripts began passing through the health offices at the national, prefectural and health center levels.

Responsibility for preparation of the monthly numeric report of births, deaths, stillbirths, marriages and divorces was transferred from local registration offices to health centers 1 January 1948. No delay resulted from this change in procedure and the regular numeric monthly reports were received on time.

Following reorganization of the Ministry of Welfare, Public Health Statistics Section was raised to the Health Statistics Department with three sections: Field Staff (temporarily including business and personnel), Tabulation and Analysis and Reports. This will permit more efficient operation than was previously possible and marks a significant advance in recognition of the important development of public health statistics in public health work.

For many months preliminary studies have been in progress, drafting plans for eventually making the Health Statistics Department an over-all Health and Welfare Statistics Department serving all Bureaus of the Ministry of Welfare. At present, it serves only four Bureaus, all of which are responsible for health matters. There are three Bureaus for which statistical services are not yet provided; Welfare, Children's and Social Insurance. Plans are being made to make the conversion early in 1949.

Revision of International List of Causes of Death,
Injuries and Accidents and Adoption of a
Manual for Selecting Joint Causes of Death

During the war there was no effort made to revise the International List of Causes of Death, Injuries and Accidents, the last revision having occurred in 1933 (Revision of 1928). Normally, the next revision would have been made in 1938. Careful study was given by the Ministry of Welfare to the revision Japan adopted in January 1947. In several instances more detailed sub-divisions of items were adopted than existed in the List adopted in the United States. However, in every case the sub-divisions were made so that they could be combined into comparable categories with those used in the United States.

In addition, the Joint Cause Manual, used for selecting the primary cause of death when multiple causes are recorded on the medical certificate of death, was adopted with slight modifications. Both the International List and Joint Cause Manual were translated into Japanese and published.

Prior to the adoption of the national uniform death registration form, only a small percent of the medical certifications contained a statement of more than one cause of death. Use of the new form, which provided a place to record the underlying cause as well as contributory causes, resulted in a rapid increase in the number of certifications with multiple causes. This, in turn, required the use of the Joint Cause Manual for the selection of the underlying cause for tabulation purposes.

In August 1947 a special National Committee of Experts was established by the Ministry of Welfare to draft recommendations for the revision of the International List for 1948. The task was made more difficult than before because morbidity was included in the List for the first time. The draft was completed and recommendations were forwarded to the Interim Committee of the World Health Organization for consideration in their study of the revision to be adopted in the spring of 1948. Several of the recommendations sent to Geneva were adopted and included in the final revision.

Further study was begun in the latter part of 1948 of the revised List prior to its subsequent adoption in Japan. Plans have already been made to call the Committee of Experts into session early in 1949 to decide upon the form in which the List will be adopted and placed in effect 1 January 1950.

In October 1948 preliminary studies were completed by the Ministry of Welfare on the new method proposed by the World Health Organization for selecting the underlying cause of death. A differential of approximately 30% was found between the new method and the Joint Cause Method currently in use. These studies are being continued.

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Statistics Committees

In order to make all possible use of persons who could give assistance in the reorganization and development of vital registrations, vital statistics and public health statistics, three National advisory groups were organized.

The first was the National Advisory Committee on Vital Statistics, to the Cabinet Bureau of Statistics, organized in July 1946. It was a composite group with members representing several Ministries, universities and private business. This Committee endeavored to expedite the work of designing registration and transcript forms for births, deaths, stillbirths, marriages and divorces. Between July 1946 and June 1947, it met 13 times.

In September 1946, the Advisory Committee on Vital Registration was organized to make recommendations for the improvement of the registration of births, deaths, marriages and divorces, which was the responsibility of the Ministry of Justice (now Office of the Attorney General). This Committee was composed of two groups of people; one group represented the chiefs of the local registration offices, of which there are approximately 11,000 and the other was made up of chiefs of the courts responsible for final enforcement of the laws concerning registrations, and to which the original registrations were transmitted for permanent preservation subsequent to their being filed in the local registration office. This Committee has been of great assistance in solving practical problems of registration because all of its members are professionally engaged in such work, either at the local or prefectural levels, or as officials of the Attorney General's Office (formerly Ministry of Justice).

In April 1947 a third Advisory Committee on Public Health Statistics was organized to advise the Ministry of Welfare on all matters concerning public health statistics, excepting vital statistics. After the transfer of vital statistics in September 1947, from the Cabinet Bureau of Statistics (Bureau of the Census) to the Ministry of Welfare, vital statistics was added as one of its responsibilities. This Committee was much larger than either of the two organized previously, and considerably more diversified in its membership, not only within the Ministry of Welfare but outside of it as well. It is composed of many sub-committees which have contributed valuable reports on a great variety of subjects. It now functions as the Advisory Council on Public Health Statistics.

Completeness of Registrations of Births, Deaths and Stillbirths

The completeness of registrations of births, deaths and stillbirths fell sharply during the war. After the registration system was revised in 1946, studies were started in January 1947 to determine the best method of checking the completeness of registrations. They were conducted for a four-month period in Chiba, Fujisawa, Kure, Hiroshima,

Omiya and two wards of Tokyo. For births, they included matching the family registration and the report of the attendant, matching birth registrations against declarations of death under one year of age and matching hospital reports of births against family registrations. For checking the completeness of death registrations, the first and third methods used for births were tested. In addition, family registrations of death were matched against cremation and burial permit. The method finally selected as the most practicable in testing completeness consists in matching registrations made by the family with reports of vital events attended by a physician or midwife. It also provides a dual reporting system.

To facilitate the submission of reports by physicians and midwives, a national uniform report form was designed and printed in post card size providing free postage. These were distributed for use in July 1947.

In July 1947, the first month the method was tested, birth registrations were found to be 96.8% complete and eighteen months later had risen to 98.1%. Correspondingly, the reports for stillbirths were 96.0% and 98.7%, for deaths 98.7% and 99.4% (Ref. charts 15, 16 and 17). The relative completeness of vital events attended by physicians has been found lower than those attended by midwives.

As the routine method of checking completeness applies only to events attended by a licensed physician or midwife, a special study was made to determine what percent are so attended and it was found to be 95.9%. Although the completeness of the remaining 4.1% not so attended is unknown, the number of unmatched registrations would seem to indicate that many are registered.

At the time the completeness checks were instituted in July 1947, another new procedure was started, which has no doubt helped to improve the completeness of registrations. By joint agreement between the Office of the Attorney General, which is responsible for registrations of live births, and the National Ration Board, arrangement was made to require presentation of official evidence to ration offices that registration of the new-born had been made before registrations for ration benefits would be accepted.

To stimulate the interest of mothers in the registration of births, a new record form was added to the Mother and Child Record Book presented to all mothers registering pregnancies. It was provided so that the family registration officials could fill out the form when the birth occurred. The mother, therefore, has an official birth record to use for purposes which might require its presentation. In 1948 laws concerning the maintenance of infant homes were revised to require the maintenance of registers which show where and when the birth of each infant under its care was registered. This serves as a deterrent to possible criminal neglect on the part of persons operating such institutions.

COMPLETENESS OF BIRTH REGISTRATION: JAPAN, 1947-1949

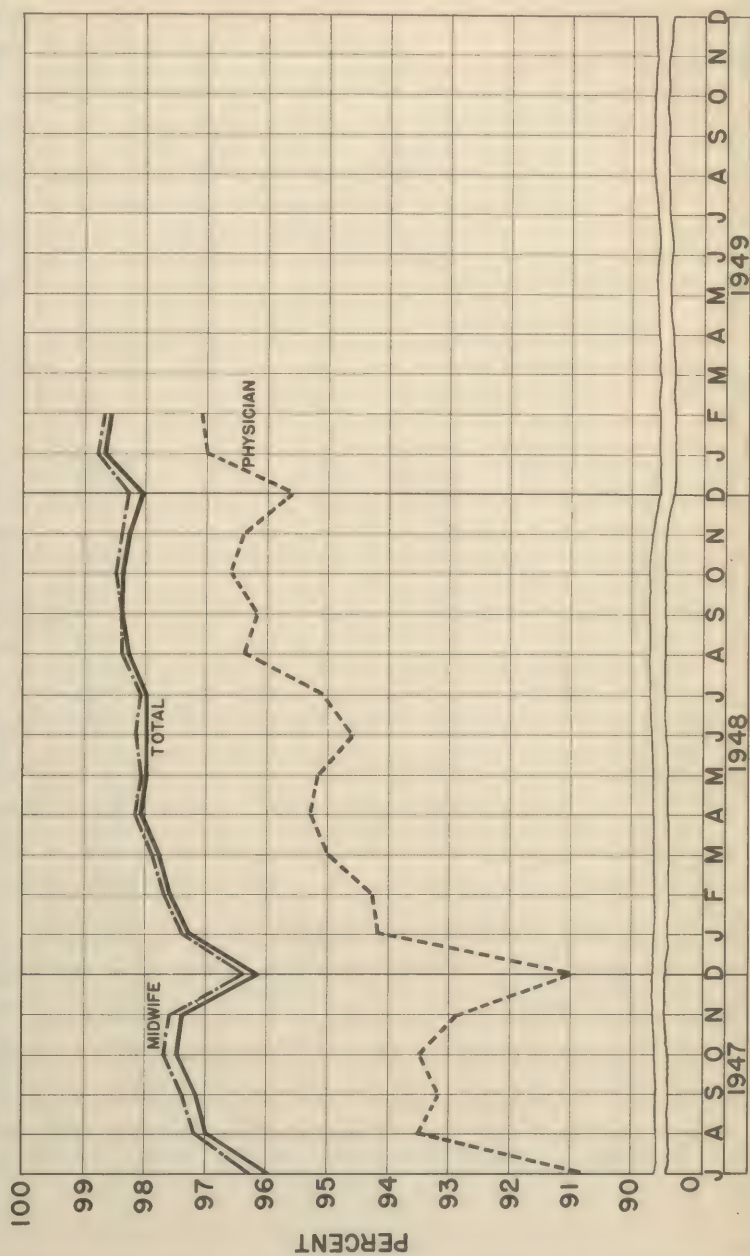
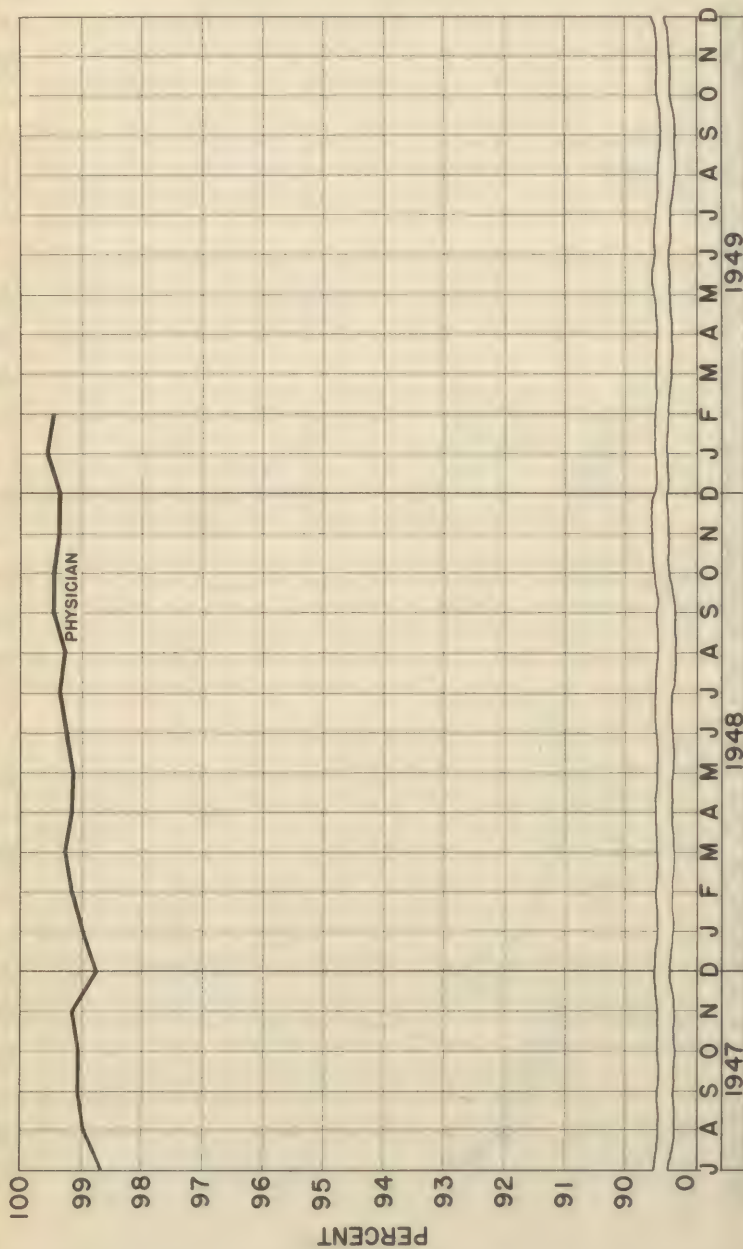
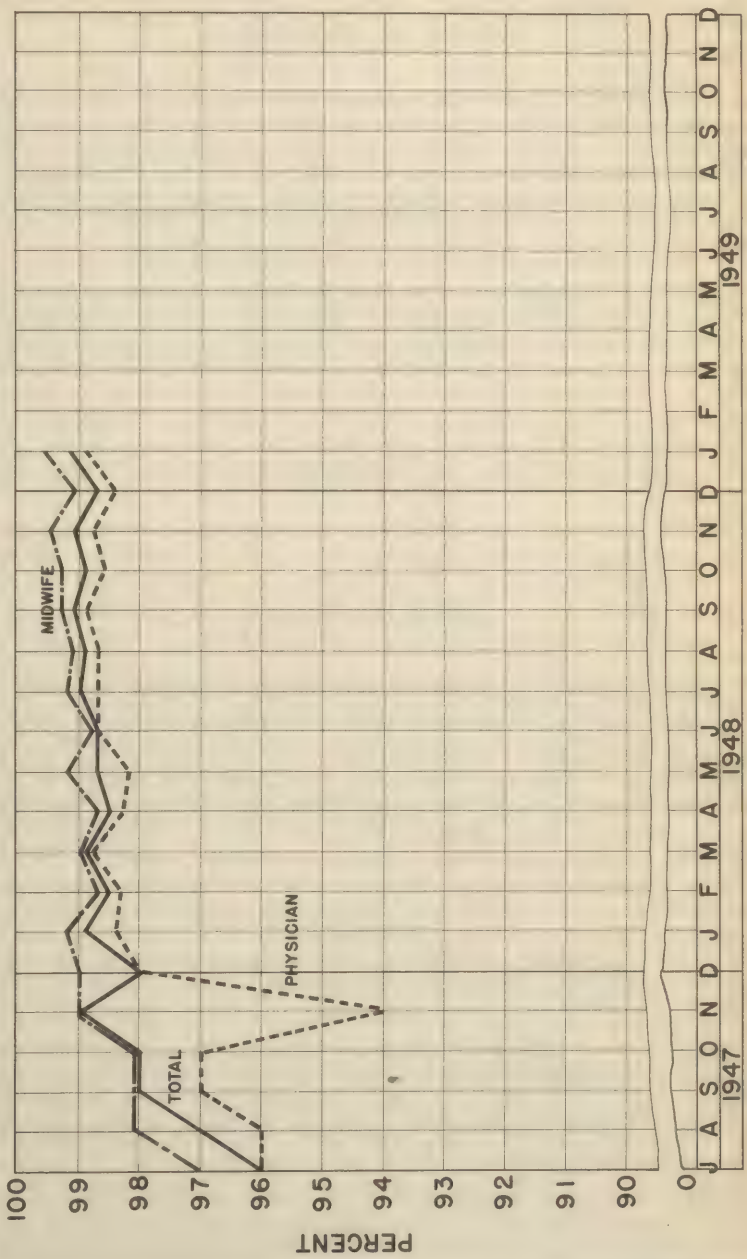


Chart 15

COMPLETENESS OF DEATH REGISTRATION: JAPAN, 1947-1949



COMPLETENESS OF STILLBIRTH REGISTRATION: JAPAN, 1947-1949



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Reports and Publications

Prior to 1946 most of the statistical reports on public health and vital statistics published by the Japanese Government were on an annual basis. They were often long delayed in publication. From an administrative point of view they were of little use. Although for many years the Ministry of Welfare received reports every 10 days on morbidity, and vital statistics data were received monthly by the Cabinet Bureau of Statistics, no current publications were made.

The first monthly vital statistics report was published in December 1946 for the month of October. Beginning in June 1947, weekly morbidity reports were published and supplied to prefectural health departments and later to all health centers. A combined annual report for 1941 - 1945 was published by the Ministry of Welfare in March 1947 containing not only morbidity data but also some for vital statistics which were saved when most of the transcripts were accidentally destroyed by fire in February 1946. In 1948 several prefectural health departments and health centers published health statistics report for the first time.

Morbidity Statistics

Before the war the reporting system for morbidity required the reporting every 10 days of diphtheria, dysentery, typhoid fever, paratyphoid fever, smallpox, typhus fever, cholera, scarlet fever, epidemic meningitis and plague. After the war, the reporting period was changed to seven days. Chancroid, gonorrhea and syphilis were made reportable in October 1945; Japanese "B" Encephalitis and malaria in May 1946; measles, whooping cough, tuberculosis (all forms), pneumonia (all forms), influenza, anthrax, glanders, leprosy, puerperal infection, rabies, tetanus, trachoma and yellow fever in January 1947; poliomyelitis in August 1947. By the end of 1947 the number of diseases required to be reported had almost tripled. The fact that morbidity reporting was limited to 10 diseases, until very recently, explains why it was not possible to include historical tabulations for many diseases in the annex to this report.

Beginning in July 1947, national uniform post card report forms providing free postage, were supplied all physicians to assist them in reporting communicable diseases. Special free postage envelope forms, which can be sealed, were provided for use in reporting tuberculosis and the venereal diseases.

The accuracy and promptness of reporting of morbidity statistics has been greatly improved. After the reports are received by the health center office in charge of communicable disease control, they are transmitted to the health center office in charge of statistics. From then on the reports become a statistical and records responsibility, and are processed by the health statistics offices at the prefectural and national levels.

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In order to furnish more complete statistical information than a simple numeric report of cases of disease, uniform epidemiological case record forms were distributed by the Ministry of Welfare in December 1948 to all the nation-wide health centers. Four different record forms were provided; one for tuberculosis, another for the venereal diseases, a third for the enteric diseases such as typhoid fever, dysentery, etc., and a fourth for the remaining acute diseases such as diphtheria, scarlet fever, etc. In addition, uniform transcript forms were supplied for the purpose of obtaining partial transcripts of information contained on the epidemiological record forms. Transcripts will be prepared each month for cases reported during the month and then sent to the prefectural health statistics offices, to be forwarded to the Ministry of Welfare where national tabulations will be made. This will provide current statistical service for morbidity comparable to that given for mortality and other vital statistics and will furnish statistics for possible epidemiological studies for any geographic area concerned during an epidemic.

Surveys

An extensive four-part medical care survey was completed in 1948. The first part included a study of the cost of services provided in hospitals and fees charged. On the basis of the findings the point system for charges was revised. The second part of the survey concerned charges made for medicines and drugs furnished in the care of hospital patients. The third part was for the purpose of determining the extent to which use was being made of hospitals. Data were obtained from approximately 3,000 hospitals. The fourth part was carried out over a one-month period to determine the extent of illness in the home. The survey was the first nation-wide study made on the cost of medical care since the war. It is planned to continue some of the studies, particularly those concerning illness in the home, so that seasonal information for an entire year may be secured.

Training Programs

Training programs have been conducted by the Public Health Statistics Department of the Ministry of Welfare and by the Institute of Public Health. In 1948 two intensive six-week courses in health statistics were conducted by the Ministry of Welfare to train chiefs and assistants in the prefectural health statistics offices. At least 125 persons received more than 200 class hours including lectures and laboratory exercises. A special one-week course in public health statistics was given for chiefs of the health statistics offices in the model health centers.

Many general health courses ranging from two to four months have been given by the Institute of Public Health, all of which have included some training in public health statistics. During 1947 and 1948, 1,207 students received a total of 17,411 class hours of training in public health statistics. Each medical officer received instruction in public health statistics amounting to 24 hours, public health

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nurses, 10 hours, sanitarians, 12 hours, nutritionists, 12 hours, veterinarians, 15 hours and pharmacists, 12 hours.

All Judicial Affairs Bureau chiefs have been called to Tokyo at least once each year to receive instruction in their responsibilities for vital registrations. There have been five national conferences of chiefs of prefectural health statistics offices. Chiefs of the prefectural health departments have been called to attend a national conference at least once each year (1946-1948). Chiefs of the model health centers were called once.

Four regional conferences of persons employed in registration of public health statistics work have been called jointly by the Ministry of Welfare and the Office of the Attorney General. The number of meetings has ranged from seven to 14 for a single regional conference. In addition to these, there have been five special conferences of midwives and registration officials which were limited to a particular geographic area.

In May 1947 the Office of the Attorney General published a comprehensive 60-page manual on registration procedures intended as a practical guide for local registration officials. A handbook of 130 pages was completed in the latter part of 1948 and is expected to be published early in 1949 by the Ministry of Welfare. A special chapter was prepared for inclusion in the handbook for midwives on the registration of births and stillbirths.

An elementary textbook on public health statistics was completed in 1948 by the Institute of Public Health for use in the courses conducted by the Institute. Publication is expected early in 1949. Copies will be furnished to all prefectural and health center public health statistics offices for reference use.

Mission on Vital and Health Statistics

During July and August 1947 Dr. Selwyn D. Collins, Ph. D., Head Statistician, U. S. Public Health Service, Washington, D.C., made a survey of the health statistics work being done by the Public Health and Welfare Section. Field trips were made to public health and registration offices in Hokkaido and southern Honshu. All feasible recommendations made for improvement in the work have now been accomplished. These include the routing of transcripts of death through health centers and prefectural health departments, making it no longer necessary to base the count of weekly deaths from communicable diseases on reports of termination of illness in death, which frequently did not refer to the cases of morbidity contained in the report. The new procedure is similar to that followed in the United States, counting deaths during the week and new cases reported during the week, regardless of the date of onset. Medical care survey forms were simplified. Suggestions for revisions in the International List were carefully studied before final recommendations were sent to the Paris Conference. Several of the recommendations made by the National Japanese Committee were adopted. Progress has been made in reducing the number of non-resident deaths of Japanese in the monthly tabulation of registrations. A few mechanical

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tabulating machines and several computing machines were obtained by the Ministry of Welfare in an effort to insure greater accuracy in tabulations of data than is possible with hand tabulation.

Conclusion

The program to be most emphasized in the future is the continuation of the education and training of Japanese personnel in the theory and practice of health and welfare statistics. Programs currently in operation, such as the training courses being conducted at the Institute of Public Health and the intensive six-week training course in public health statistics, will be continued and expanded. Similarly, regional and local training programs will be broadened as a means of increasing the efficiency of operation of all prefectural statistics personnel. In this connection, the procurement of adequate supplies of library reference material and publication of instruction manuals and guides will be given close attention during the further development of the educational program.

The administration of the health and welfare statistics program will be studied not only to improve the efficiency of reporting procedures, but also to effect savings in time. It is planned to study the possibilities of microfilming all completed forms to insure their preservation and also as a means of conserving paper and eliminating storage space. The acquisition of mechanical tabulating equipment will be seriously considered to speed up the completeness and accuracy of reports.

Further revisions will necessarily be made in the International List of Causes of Death and the Manual for Selected Causes of Death to conform to recommendations of the World Health Organization. This will also entail certain revisions in registration and transcript forms to conform to international standards in time for the planned WHO program for comparable world-wide statistics in 1950 on vital statistics and morbidity.

Sanitation

Sanitation in Japan is a combination of modern and medieval practices. The rigid economy forced upon the nation by virtue of overpopulation and limited natural resources resulted in the adoption of many strange living habits and customs, some of which have remained unchanged for centuries. The use of night soil for fertilizer, public bathing in community bath houses, sleeping and living on "tatami" (floor mats) in small, crowded houses, lack of sufficient quantities of fuel with which to cook food and heat living quarters, and many other customs present many important and unusual problems in public health.

Prior to the Occupation, control of environmental sanitation was accomplished through the Eisai Kumiai (Sanitary Associations). These associations were small local organizations of home owners. The members were compelled to pay dues which were used to defray the expenses of vaccination programs and other sanitary services for the

communities. The associations made contracts for the collection and removal of garbage, refuse and night soil.

Twice a year clean-up programs were conducted which were designed to stimulate each householder to clean up his house and premises. Volunteer groups were organized to clean the ditches and street drains and to remove or bury the accumulation of trash and litter. Inefficient perfunctory rodent control programs were carried on utilizing any means at hand such as traps, poisons and clubs. During these clean-up campaigns homes were inspected by the village headman, together with the police, and the people whose homes were not clean to the satisfaction of the inspectors were fined and forced to clean up again.

These sanitary associations were later taken over by the Tonarigumi (Block Association), a war-time political organization through which the government regimented the population and controlled their activities completely.

The Tonari, Eisai Kumiai and other similar organizations have been banned by SCAP directives. Their functions have been assumed by local governmental public health organizations established along democratic lines under the new Japanese constitution. Local environmental sanitation functions are now carried out under the supervision of these local governmental public health agencies (health centers), the operations of which are financed jointly by the national, prefectural and local governments. Inspection authority has been vested in trained sanitary inspectors, and active insect and rodent control is carried on by sanitary teams working under the direction of the health centers.

Formerly there was little correlation of functions and services with respect to public water supplies, waste collection and disposal and insect and rodent control. Only in case of infectious diseases did the so-called Public Health officials take action and then the action was primarily directed toward control of the individual in an effort to prevent the disease from spreading.

Organization of Sanitary Teams

Recognizing the immediate need of improving general sanitary conditions, efforts were first directed to the clearing and removal of debris resulting from the war, the repairing of damaged water supply systems and to generally improve environmental sanitation. Medical and sanitary supplies were obtained from confiscated Japanese Army - Navy and surplus U. S. military stocks and distributed on the basis of greatest need. Six-man sanitary teams were organized and used for typhus control; their activities consisting chiefly of eliminating the louse population. Under the supervision of Occupation Force personnel the training of these teams was extended during the spring of 1946 to include all phases of insect and rodent control. Training schools were conducted at Kyoto and Sendai for the benefit of Japanese personnel working on these sanitary teams, and later a training school was conducted in each of the nine regions in Japan. These have been expanded with a course now held in each prefecture each year.

Due to limited amounts of insecticides, equipment and funds, efforts during the early part of 1946 were largely directed toward epidemic disease control. However, before the end of the year, 9,000 teams, employing 54,000 persons, were actively engaged in insect and rodent control activities.

Concurrent with the growth of the sanitary teams, steps were taken to provide sufficient supplies of insecticides, rodenticides and other sanitary supplies and equipment. Beginning with 1947, funds were provided in the Ministry of Welfare budget for subsidizing these teams on the following basis: 50% national, 25% prefectural and 25% local governments.

The number of sanitary teams has been reduced from one per 2,000 population in 1946 to one per 13,000 for 1948, and it is anticipated that it will level off in 1949 to one per 15,000. The decrease has been made possible by the improvement made in environmental sanitation and the remarkable reduction in insect-borne diseases. These teams are on a permanent basis and can be augmented by volunteer teams at the local level in case of a threatened epidemic.

Insect and Rodent Control

Consistent progress has been made in the reduction of insect-borne diseases through active insect and rodent control and the gradual improvement of environmental sanitation. Persistent effort in cleaning up and eliminating breeding places of noxious insects, the repair of municipal waste collection and disposal facilities, and the reactivation of municipal agencies responsible for public sanitary services has materially reduced the hazard of insect-borne diseases.

Ample supplies of insecticides and equipment have been procured (through importation and local production) and made readily available for insect control purposes. The production of insecticides and equipment by Japanese manufacturers has steadily increased over the past three years to the point where further importations from the United States are not necessary.

Insect control measures which are carried on routinely by sanitary teams consist of larvae and adult insect control by (1) the elimination of larvacidal treatment of breeding places and (2) the destruction of adult insects with appropriate insecticides. Details of the measures for control of specific diseases are outlined under the discussion of each disease.

Intensive training programs have been carried on in the spring and fall to instruct sanitary team members in the use of insecticides and the proper techniques of application.

Rodent control has consisted chiefly of (1) extensive information-education programs, (2) wide scale baiting and trapping programs carried on periodically under the direction of the sanitary team personnel, and (3) the elimination of rat harborages and food sources through removal and proper disposal of rubble and garbage.

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Through the food sanitation program much has been accomplished toward protection of food supplies from contamination by rodents and insects.

Water Supplies

Immediately upon entering Japan a survey was made to determine the actual condition of all public water supplies, including the types and quantities of materials necessary to put them in good operating condition.

Immediate provisions were made for adequate amounts of chlorine and chlorination equipment necessary to protect all public water supplies. Actual control and supervision of all water supplies furnishing water to the Occupation Forces was accomplished by U. S. Army Engineers.

Due to shortage of raw materials with which to manufacture chlorine, the Japanese did not practice routine chlorination except for certain supplies definitely known to be non-potable. Usually they depended upon purification by filtration alone. Since the Occupation, indigenous production of chlorine has increased to the point where the quantities now being produced are adequate to meet minimum requirements.

In many of the large municipal water plants, on-the-job training of waterworks operators has been accomplished. Modern methods of water treatment with particular emphasis on chlorination and bacteriological examinations has been emphasized.

Courses in water purification and waterworks inspection have been incorporated in the courses for sanitarians and sanitary engineers at the Institute of Public Health.

Encouragement and assistance in the improvement of existing facilities and the installation of new systems is being given to towns and villages by the Ministry of Welfare.

Plans and specifications for improvement of wells have also been prepared and made available to the public through the health centers.

Waste Disposal

The greatest single environmental sanitation problem involved the utilization of night soil as fertilizer. Due to the lack of chemical fertilizer approximately 50% of the plant food necessary to produce sufficient food-stuffs for the nation is derived from farm manures, a large portion of which is night soil. The night soil is either collected manually by farmers who use it for fertilizer, or by contractors who collect and transport it to the country where it is sold to farmers, or by individuals using the material on their gardens. This system has obviated the necessity of municipal responsibility for providing

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collecting facilities. Consequently, for many years little or no progress has been made in the methods of collection and handling of night soil. The bucket and dipper is used to remove the material, and man or animal-drawn vehicles are used to transport it to the country.

With the development of large industrial centers, this service became more and more of a problem until the large communities were finally compelled to assume responsibility for disposal in certain areas where congestion forbade the use of the manual method of collection. Consequently, sewer systems and sewage disposal plants were installed in certain sections of the larger cities. The extent of the systems was very limited in the area covered and often carried only the waste water from lavatories and kitchens. Since these systems required a large increase in the already limited water supplies, together with the expenditure of tremendous amounts of funds and critical material, many of the projects were only partially completed and remain so up to the present time.

There are no prospects of Japan being able to discontinue the use of night soil for fertilizer in the near future. Consequently, efforts have been directed toward control of its usage so as to minimize the public health hazards involved and to improve the methods of collection and handling from the sanitary, economic and aesthetic standpoint.

Existing regulations requiring sufficient treatment to destroy pathogenic organisms and ova which were relaxed during the war years are being put back into force. Necessary amendments are being made to effect practical changes.

Research is being conducted in an effort to effect improvement of methods and facilities for handling the material. For example, the use of vacuum tanks for collection, digestion and dehydration plants for treatment are being investigated. The long-range program involves the installation of sewer systems with treatment plants incorporating digestion and dehydration processes.

Garbage and other household refuse, which are considered as commodities, are collected and disposed of in much the same manner as night soil. For example, this material is collected, sorted and disposed of according to its economic value. The organic material is composted and used for fertilizer. During the war refuse collection was neglected, which resulted in the accumulation of large quantities of garbage and other refuse scattered throughout most of the cities, towns and villages. This resulted in excessive rat and fly breeding and contributed to the high incidence of enteric diseases.

Removal of this garbage and refuse which was started early in the Occupation, together with the use of insecticides and other fly control measures, has reduced the fly population to a very low level. This program has contributed immeasurably to the control of enteric diseases.

The collection and utilization of waste material is now being carried out under the supervision of the sanitary teams and inspectors from the health centers. These services generally have been returned to pre-war standards or improved beyond prewar levels insofar as

available funds and materials have permitted.

Long-range plans for future improvement have been formulated; however, the rapidity of accomplishment of the program is dependent to a great degree upon the availability of funds and materials.

Personnel Training

Lack of trained sanitation personnel was the greatest handicap in the establishment of the sanitation program. There were no sanitary engineers or sanitarians, as such, working in Japan. Public health activities included little in the way of environmental sanitation and Japanese officials have been reluctant to recognize the need for trained sanitarians in public health work.

To overcome this difficulty, training courses for sanitarians and sanitary engineers were established at the Institute of Public Health. Both courses, of three-month duration, are attended by students sent from each prefecture. These courses are designed to give basic training in environmental sanitation and to prepare the students to carry out sanitary training programs in their prefectures. To date, 272 sanitarians and 64 sanitary engineers have been graduated. (More details concerning these courses will be found in this chapter under Institute of Public Health).

In addition to the above, four-year courses for sanitary engineers are now included in the curriculum of Tokyo and Kyoto universities. Plans are also being formulated for a one-year graduate school for public health engineers at Tokyo University.

Long-range plans for improvement in the environmental sanitation program have been formulated; however, the rapidity of future progress is dependent, to a great extent, upon the availability of funds and materials. Future plans include (1) completion of the sanitation organization in all health centers (local level of administration) and (2) improvement in the local environmental sanitary administration, particularly the coordinations of functions of the inspectors, sanitary teams and others concerned, at the local level.

Long-range plans also include improvement in water supplies, installation and operation of night soil and sewage treatment plants, repair and extension of drainage systems, study of housing problems and education of sanitation personnel. To this end, Military Government sanitary engineers have already been assigned to each of the nine Military Government regions in Japan. These men are actively engaged in supervising the sanitary programs and training of indigenous sanitation personnel.

Port Quarantine

Prior to the war the Japanese quarantine system was operated by prefectural and local governments without national coordination.

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Quarantine provisions, therefore, varied according to local ground rules and lacked uniformity. While Japanese prefectural quarantine regulations appear to have served the requirements of the nation, they were far inferior to modern international quarantine control procedures.

During the war, barriers that had existed against quarantinable diseases completely broke down. Quarantine personnel had been inducted into the armed services in such numbers that all stations became understaffed. Facilities were stripped of equipment, which was turned into scrap metal urgently needed for military requirements. As the war progressed, quarantine functions gradually ceased, except for incoming and outgoing military personnel.

The disruption of normal functions immediately prior to the capitulation resulted in all quarantine station activities coming to a standstill, and presented a definite threat of importation of communicable diseases, especially in view of the planned repatriation program.

Organization of Quarantine Stations

The first step toward reorganization of the quarantine service was the adoption and publication of port quarantine regulations in August 1945. While stringent compared to the requirements of a modern nation, the high communicable disease incidence in Japan and other nations in the Asiatic area necessitated the adoption of such strict measures.

Eight ports were selected and designated as quarantine stations and a full complement of personnel assembled and trained, in addition to procuring medical and laboratory equipment and supplies from confiscated Japanese Army - Navy stocks and surplus U. S. Army stocks. This was a high priority undertaking, and by utilizing both U. S. and Japanese personnel, a coordinated national quarantine service was formed and placed under the control of the Ministry of Welfare in time to handle all the medical processing of repatriates who began arriving in September 1945.

Under the supervision of the Public Health and Welfare Section and Military Government port quarantine officers, quarantine controls proved successful in preventing the entrance of communicable diseases into Japan. The largest mass repatriation program in history, approximately 6,135,979 persons to Japan and 1,184,350 persons from Japan up to 31 December 1948, was completed without incident, and furthermore, at no time in this program did there exist any danger of diseases among the Occupation Forces. Some 469,059 persons still remain to be repatriated to Japan, principally from Soviet-occupied areas.

The following instances are cited as being indicative of the magnitude of the quarantine problem and the value of strict quarantine procedures enforced by the Supreme Commander for the Allied Powers. The occurrence of 711 proven cases of cholera and 479 carriers aboard 114 vessels resulted in 232,907 persons being detained in quarantine. These vessels arrived in Japan from Bangkok, Haiphon, Canton, Kongmoon, Shanghai, Hulutao and South Korean ports. More than 120,000 of these persons had been embarked in Hulutao alone. Two hundred fifty-five

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cases of typhus fever were discovered among repatriated on 52 vessels, most of which arrived from China, Manchuria and Korea. Two hundred seven of these patients were from middle China. One hundred seven cases of smallpox were discovered on 54 vessels from middle and northern China, Manchuria, Okinawa and Formosa, with China and Manchuria contributing the majority. Constant vigilance and effective supervision has been necessary to prevent the introduction of major epidemics in Japan.

During 1946 there were several small outbreaks of smallpox and cholera in the southwest areas of Honshu and the western area of Kyushu bordering on the Japan Sea. Subsequent investigations traced these to illicit shipping and smuggling of personnel from Korea and the Asiatic mainland. Rounding up these illegal entrants, medical processing and then deportation, has eliminated this danger.

In December 1946, eight seaports of entry and two airports of entry were officially designated as quarantine stations to control the normal entry and exit of international travelers to and from Japan. In the fall of 1947 the designation of five additional seaports provided for more efficient quarantine controls.

Seaports currently in operation are:

Otaru	Nagoya	Miike	Hakodate
Yokohama	Kobe	Nagasaki	Shimizu
Moji	Sasebo	Osaka	Yokosuka
Kagoshima	Kure	Hakata	

Airports are Haneda and Iwakuni.

In addition to the ports listed, repatriation centers are maintained at the ports of Hakodate, Maizuru and Sasebo.

Repatriation from Soviet areas, discontinued during the 1947 - 1948 winter season, was resumed in April 1948. Repatriation centers, which had been kept on a standby basis, were placed in full operation on 24 hours' notice and were able to resume all functions without delay. Repatriation from Soviet areas was again discontinued at the end of November 1948.

Medical Processing of Repatriates

Medical processing was started immediately upon arrival of a repatriation ship in port. Ships were placed in quarantine while a thorough examination was conducted on all repatriates, including a check on immunizations.

In those instances where cases of communicable diseases, such as cholera, typhus, plague, smallpox, etc., were found, they were removed to isolation areas, under medical treatment. The remaining repatriates were kept in quarantine for 14 days, pending possible further occurrence of disease aboard ship. At the end of this period, if no additional cases developed, repatriates debarked for processing and

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transportation to their destination. However, if further cases were found, an additional 14-day quarantine period was required from the date of the last proven case.

When inspections and examinations disclosed no communicable diseases aboard ships, a minimum period of six days, retroactive to the date of embarkation, was required before repatriates were permitted to leave the ship for processing. This was necessitated by the known fact that repatriation points of origin were in areas where cholera, typhus and smallpox were prevalent.

As most vessels in the repatriation program were able to make the trip from the mainland to the reception centers in two or three days, this brief quarantine period permitted a further check on possible communicable disease among repatriate groups.

The majority of repatriates did not receive proper medical processing prior to embarking; therefore, included in the medical processing at the repatriation center were provisions for giving all necessary immunizations. Repatriates were also given chest X-ray examinations, and in addition, had all their clothing and bedding and their persons dusted with 10% DDT dust to remove fleas and body lice.

Laboratory facilities, at each quarantine station, were used extensively in proving cases of communicable disease and in determining suspects. Also included was a complete stool examination of each individual.

During the peak of the repatriation program, the repatriation centers at Hakata and Uraga were equipped to process 15,000 repatriates each, per day.

Quarantine Regulations

Peace-time quarantine regulations were prepared and became effective in December 1946. The seaports and airports of entry are operated by Japanese personnel under the supervision of Military Government port quarantine officers.

Due to changing conditions, stringent immunization requirements, which were necessary in 1946 when the original quarantine regulations were published, were revised in March 1948 to bring them more in line with standard international quarantine practices.

The current regulations are considered sufficient to control all surface and aircraft entry and exist to and from Japan. No new specific future programs are contemplated, except for the continuation of present operations and improvement of control activities.

Laboratories in Japan

At the beginning of the Occupation a limited number of laboratory facilities were found in Japan. Apparently no previous effort had been made or planned to control, standardize or evaluate the diagnostic clinical laboratories that did exist. Likewise, there had been no real effort to control or regulate either the number, type or quality of the so-called biological products.

Although there was no real administrative organization for the supervision of these activities, the government had issued licenses for the production of certain biologic products. No attempt had been made to license all of them. Minimum standards of quality at the national level existed for only two products; diphtheria and tetanus antitoxic sera.

The organisms used for the production of the various biologics throughout Japan varied from laboratory to laboratory with resultant variations in the final products. Investigation revealed that these strains of organisms were in many cases non-antigenic or otherwise undesirable for use.

Such standards as had been maintained before the war ceased to exist as the war progressed. Conditions existing as the result of the war were such that either production or control were virtually impossible. A considerable number of biologic plants and other laboratory facilities were destroyed.

Many doctors were inclined to research and, although there were a few qualified laboratories and research men who were doing acceptable work, in general the facilities were inferior and the programs conducted were of dubious quality.

Vaccine Production and Assay

At the beginning of the Occupation there was a desperate need for acceptable biologic products of various types for the prevention and control of communicable diseases in Japan.

One of the first projects undertaken was the production of sufficient smallpox vaccine to immunize the entire population of Japan. Using techniques familiar to the Japanese, this task was accomplished; however, the techniques employed and the quality of the resultant product were not entirely satisfactory and it was necessary to repeat immunizations in certain areas. Nevertheless, the nation-wide immunization program was completed.

Large quantities of cholera and typhoid vaccines, and diphtheria toxoid have also been produced. Until recently these were produced without satisfactory minimum standards or assay.

Minimum standards of quality and techniques for the production of typhus vaccine were furnished so that sufficient quantities of acceptable vaccine to meet requirements were produced.

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In 1946 a Laboratory Control Section was established in the Ministry of Welfare and a national laboratory control program was inaugurated. Suitable cultures for the production and assay of biologic products and for aid in diagnostic work were obtained from various reputable laboratories in the United States. Official tentative minimum standards of preparation and quality for Japanese produced typhus and cholera vaccines, typhoid-paratyphoid vaccine, and diphtheria toxoid were then promulgated and distributed to the various manufacturing laboratories. Minimum standards for other biologic products are in the process of study and development and will be approved as rapidly as possible.

The National Institute of Health, staffed by some of the leading scientists of Japan, was established in May 1947 to fill an urgent need to control biologics and do fundamental research on communicable disease control. This Institute is an agency of the Ministry of Welfare, and the first such official governmental agency to be established for the control of biologics. It has the responsibility for the supervision of the procedures employed for the production and control of biologics, and for the highly technical assay of biologic and antibiotic products. In addition, it is authorized to carry out fundamental research on all functions of biologic production and assay, and disease control.

A system of national and local laboratory inspectors has been organized to exercise surveillance over diagnostic and biologic laboratories in observance of official directives and regulations. Instruction courses for inspectors and manufacturers of biologics are being conducted to assist in the firm establishment of the National Laboratory Program.

The task of biologics production and control has been a gigantic one. Close supervision has enabled the production of sufficient products to meet, with few exceptions, the acute demand. From the standpoint of disease control, this program has been unbelievably successful. The products used have not been of the highest quality in every instance; however, they have been sufficiently good to meet the emergency conditions. Steps are now being taken to place the biologics program on a more safe, more satisfactory basis in order to insure the permanent availability of products of the highest quality from the standpoint of purity, safety and effectiveness.

The production of BCG vaccine which was formerly carried out in ten or more laboratories is now being carried out in one central laboratory under close supervision. There has been an acute need for this product in conjunction with the tuberculosis control program. Centralization was necessary to eliminate defects in the methods of preparation, distribution and assay.

Research

Research activities on the production and assay of biologicals and antibiotics, including research on disease control, is being carried out at the National Institute of Health in Tokyo. While this program has only developed during the past year, plans provide for an expansion of their activities.

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(Note: More information on the activities of the National Institute of Health will be found under this subject).

The initiation, development and adoption of more efficient minimum standards of preparation and quality of biologic products, in order to insure their purity, safety and effectiveness, is planned. Surveys and studies of the facilities, personnel and activities of public health laboratories will be continued. These studies are a part of the plan for the immediate further extension of the laboratory control program to include prefectural public health laboratories. It is considered desirable to control these laboratories by a licensing system which will include standardization of methods, personnel training, facilities and equipment available.

The National Institute of Health (NIH)

An Institute under central government supervision designed to control the assay of biological products, as well as to conduct fundamental research on problems of national importance in the field of public health, did not exist in Japan prior to the occupation. The nearest approximation to such an organization was the Institute of Infectious Disease in Tokyo which had been in existence for many years. Formerly under the Home Ministry, it was transferred, in 1933, to Tokyo University which was under the control of the Ministry of Education.

The primary function of the Institute of Infectious Diseases was that of a medical research institute for the university. As a secondary function it acted as an agent for the Ministry of Welfare in matters relating to licensing of biological laboratories and assay of their products. At the same time it became one of the largest manufacturers of biologic products in the nation; thus, the Institute sat in judgment over the products of other commercial manufacturers as well as its own products, which were produced in competition with private enterprise.

Organization and Functions

Although the need for an official government public health institute under the direct control of the Ministry of Welfare was very evident, a considerable period of time elapsed before funds, facilities and personnel could be obtained to organize such an institution.

It was not until 21 May 1947 that the National Institute of Health (NIH) was formally dedicated as an official organ of the Ministry of Welfare. It is a semi-independent organization directly responsible to the Minister of Welfare and has been staffed with leading scientists of Japan, gathered from various universities throughout the nation.

The primary functions of the National Institute of Health are:

1. The establishment of standards for biologic products and qualitative control of all biologicals and antibiotic products produced in Japan.

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2. The conduct of fundamental research on problems of national importance in the field of preventive medicine.

3. Upon the resumption of international relations, to act as the official Japanese organ in maintaining liaison with similar institutions throughout the world.

The Institute has three departments, namely: Department of Research, Department of Assay, and Department of Experimental Production of Biological Products. These departments are further broken down into 14 divisions which adequately handle all necessary functions and responsibilities of the Institute.

Research Programs

During the summer of 1947 American scientists, working jointly with Japanese scientists, conducted or continued research studies on the following projects:

1. Research studies on Ekiri. An American scientific mission supported by a grant from the United States Public Health Service was in Japan for 90 days conducting research studies in Ekiri, a disease of children. Their findings proved that Ekiri is primarily a dysentery complicated by the loss of calcium from the blood, resulting in activation of a latent tetany. Under their guidance, steps were taken to control this disease. The work has continued under the auspices of the Japanese scientists, with training classes being held to teach the Japanese the techniques of evaluation of the level of calcium in the blood.

2. Research studies on Japanese "B" Encephalitis, which originated in the early summer of 1946, have continued to date.

3. Research studies on schistosomiasis, which were started in 1946, have been continued to date and include surveillance of various prefectures where this disease is quite prevalent.

4. Genetic studies on the victims of the atomic bomb in Nagasaki and Hiroshima have, in coordination with the American Atomic Bomb Casualty Commission, been conducted since their origination in the fall of 1945. Establishment of branch field units in the Nagasaki and Hiroshima areas, with a central department in Tokyo, are currently in effect.

During this period, antibiotic research studies have made considerable progress. A penicillin pilot plant was completed in May 1948, and marked the beginning of studies of production methods on the semi-plant scale at the National Institute of Health. The Assay Department at the National Institute of Health has increased its scope of activity to embrace the assay of all biologic products.

Future programs include the immediate acquisition of more adequate, badly needed laboratory facilities, storage space and animal quarters. The growth of the laboratory control program has indicated the need of a general reorganization of the departments and divisions of the Institute. This reorganization will be carried out in such a manner as to streamline and place more responsibility on a smaller

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number of individuals for the assay of biologic products. The reorganization will result in a more efficient assay program. It will include a specific assay department broken down into test units of a specific type; i.e., chemical analysis, sterility test, safety test, potency test, etc. The test production section will also be within this department.

A department of cancer research will be established within the research division. At present there is no cancer research project under any central government institute. The research division will also include a department for integrating the studies being conducted under the atomic casualty research program.

The Institute of Public Health (IPH)

Prior to 1930 little attention had been paid in Japan to the training of workers in the field of public health. During the early 1930's the Rockefeller Foundation became interested in this problem and subsequent negotiations between the Foundation and the Japanese Government resulted in the establishment of the present Institute of Public Health.

Funds for the construction and equipment of a modern seven-story building were donated by the Rockefeller Foundation. Construction was begun in 1935 and completed in 1939.

The Institute of Public Health, however, emphasized research activities and accomplished comparatively little in the training of public health workers. All activity was suspended in 1943 when the Ministry of Welfare occupied the building for the remainder of the war period.

Reorganization

There was a great need in Japan for workers trained in public health. The only qualified public health officials, mostly doctors, were the few who had been educated abroad, principally in the United States, England and Germany. Accordingly, early in 1946 a program was adopted to reestablish the Institute as an institution for teaching public health.

Initiation of this program was delayed because of lack of funds, facilities and personnel. Early in 1947, however, members of the Public Health and Welfare Section, officials of the Ministry of Welfare and key staff members of the Institute of Public Health completed plans to initiate refresher courses for seven different types of public health personnel, and at the same time made arrangements for the Ministry of Welfare to begin vacating the building.

Public Health Refresher Courses

The first of the refresher courses, for public health nurses, was started on 2 April 1947. The initial classes for public health medical officers (doctors) and for sanitarians began on 16 June 1947. On 9

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January 1948 courses were opened for public health pharmacists and veterinarians.

In May 1948 courses for public health nutritionists and public health engineers were opened, which completed the original plan to give training to seven different categories of public health personnel.

To date the following numbers of courses have been completed:

	<u>Length of Course</u>	<u>Number of Courses</u>	<u>Students Attended</u>
Public Health Medical Officers	3 months	6	248
Public Health Nurses	4 "	5	267
Sanitarians	3 "	6	272
Public Health Veterinarians	2 "	4	179
Public Health Pharmacists	2 "	4	172
Public Health Nutritionists	2 "	3	117
Public Health Engineers	3 "	2	64

The students attending these courses are personnel currently on duty with the official public health agencies throughout Japan. Approximately 40 to 50 persons attend each class, representing most of the prefectures and larger cities.

The courses present a short, intensive review of basic public health subjects and an explanation of policies and technical procedures to be used in putting into effect a modern public health program in Japan.

In addition to the refresher courses, a series of special short courses of one-week duration were conducted during the latter part of 1948 to properly orient and instruct the various categories of key personnel in the model health centers.

In June 1948 a public health consultant from the Rockefeller Foundation was placed on loan for two years with the Public Health and Welfare Section to coordinate all activities at the Institute of Public Health and supervise the teaching program. In the fall of 1948 a donation from the Rockefeller Foundation permitted the reopening of the library reading room by furnishing current medical books and public health publications.

Future plans provide, primarily, for expansion and improvement of the educational facilities of the Institute. Present refresher courses will be continued to meet the emergency need for trained personnel to staff the prefectural health departments and health centers. A full year course is being instituted to provide more adequate and fundamental public health training for public health medical officers (doctors). In all teaching activities, nearby health centers will be used to a greater extent as field training areas.

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Public Health and Welfare Information and Education

Prior to the Occupation a public health and welfare information and education program had never existed in Japan and the idea was entirely foreign to Japanese concepts of public health administration. During the first two years of the Occupation, little effort was expended in this direction, due to the urgent need to establish other measures for the prevention and control of communicable diseases. In the fall of 1947, recognizing that a population enlightened in public health matters is essential to the success of the nation-wide public health and welfare organization, plans were made to develop an information and education program.

Central Coordinating Council

The first step toward the coordination of public health and welfare information and education activities was taken with the establishment of a Central Coordinating Council composed of representatives of the various Ministries of the Japanese Government. Its primary function is to establish definite policies and coordinate activities pertaining to planning and execution of public health and welfare information and education programs designed for the general public and for the school health program.

After a period of relative inaction the council, in 1948, restated its aims and now promises to become an organization of great value in the information - education program. With SCAP approval, the Ministry of Welfare has inaugurated a long-range plan for Japan. This plan, embracing two distinct fields of work, namely, (1) public health and welfare information and (2) health education, stresses the necessity for close correlation and coordination of all health and welfare information and education activities at national, prefectural and local levels.

Dissemination Media

In April 1948 an Information Unit was established in the Ministry of Welfare. It serves to coordinate all health and welfare information activities of the Ministry and to disseminate such information to the public. The Unit functions as a sub-section of the General Affairs Section of the Ministerial Office, but is directly responsible to the Vice-Minister.

A committee of lay Japanese personnel was made responsible for assembling and checking material on health subjects for release over a 15-minute daily radio program, Monday through Friday. This radio program is devoted exclusively to the promotion and advancement of public health and welfare. Current health and welfare information as well as materials concerned with anticipated emergencies is broadcast three times daily during station breaks between programs, with changes in subject matter every three days. Supplementary health and welfare information is also released over several other radio programs in which

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this type of material is handled. The Ministry of Welfare and the Broadcasting Company of Japan have cooperated excellently in the execution of this phase of the program.

Information and education activities are centered around the seven most important public health and welfare problems and include communicable diseases, venereal diseases, tuberculosis, mother and child health, nutrition, sanitation and welfare. Information concerning other problems is incorporated with the subjects mentioned. The program is flexible enough so that special campaigns and emergency programs can be handled. The dissemination of public health and welfare information is also being made through other media, such as the press (newspapers, magazines), special publications, (pamphlets, leaflets) and visual aids (motion pictures, slide films, posters). In this way the public is kept continuously aware of public health and welfare activities. Evidence that the general program is gaining success is indicated by the numerous letters that are received from the general public.

The staff of the Information Unit (numbering at present 16 members) though somewhat inexperienced in this work, are being trained for their jobs through the combined efforts of various Japanese agencies with aid and support from SCAP sections.

The Ministry of Labor, in cooperation with the Ministry of Welfare, inaugurated in 1948 a health information - education program in an attempt to raise the standards of health and sanitation in the coal mining areas in Japan.

Public Health Train

On 1 November 1947 in Tokyo, an impressive ceremony was held for the opening of a Public Health Train Exhibit. This train, consisting of three converted railway coaches, contained exhibits, charts, diagrams, pictures and models dealing with nutrition, tuberculosis, venereal diseases and other communicable diseases, parasitic diseases, public health nursing, dental hygiene, social security, environmental sanitation and veterinary activities.

The Public Health Train completed an exhibition tour of Japan in August 1948. Thirty-three cities in widely separated areas of Japan were visited and approximately 900,000 people were afforded the opportunity of viewing the exhibits on display. The train was discontinued in September 1948.

Health Education

Attempts have been made with varying degrees of success to secure coordination and correlation of health education activities as exercised by the Ministry of Education and the Ministry of Welfare in an effort to establish:

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1. A sound, progressive school health program including:

- (a) School Health Administration
- (b) School Health Instruction
- (c) School Health Services

2. Refresher courses in the field of public health for professional groups.

3. Training for special groups of persons (Mothers' Clubs, PTA, etc.)

Plans are now in progress to develop and establish a model school health program in the Kanto Region of Japan which may serve as a basic plan for other regions to follow. The health education divisions of the health centers are being encouraged to actively participate and cooperate in the general public health and welfare information and education program.

Plans for the future include the establishment of an information unit at the prefectural level within the general affairs sections of the prefectural health departments, planning of special types of programs for release via radio and improvement in the section of subject material and preparation of scripts for motion pictures, film strips and other visual aids. Encouragement will also be given to cooperation between Japanese press, radio broadcasting companies and private concerns interested in the promotion of public health and welfare.

In the field of health education, it is planned to increase cooperation in and participation of the health centers in the school health program and establish sound, progressive school health instructional projects.

Chapter 3

MEDICAL CARE

Medical Education

At the time of surrender Japan possessed an adequate number of doctors although a good percentage were graduates of second class medical schools. These institutions had limited clinical and educational facilities and, as a result, the graduates were poorly prepared for the practice of medicine.

For many years medical education had followed the didactic German system; therefore, the development of laboratory and clinical teaching methods requisite to the production of trained practitioners was neglected. Instructors qualified to teach medical students refused to participate in the undergraduate teaching program preferring to confine their activities to select graduate students who had elected to qualify for the higher degree of Doctor of Science in Medicine (Igaku Hakushi).

Prior to the war there existed a total of 18 university level schools having medical departments of a relatively high standard. Seven of these medical schools were departments of Tokyo, Kyoto, Tohoku, Kyushu, Hokkaido, Osaka and Nagoya Imperial Universities. Six medical colleges of university level, Niigata Medical College, Okayama Medical College, Chiba Medical College, Kanazawa Medical College, Nagasaki Medical College and Kumamoto Medical College, were operated by the national government but were not of imperial university rank or calibre. One medical school was operated by prefectural (State) government, the Kyoto Prefectural Medical College. Four private organizations operated medical schools; Keio University, Jikkei-kai Medical College, Nippon Medical College and Nippon University.

A degree equivalent to that of Doctor of Medicine was given upon completion of four years of medical school training, entry to which required a preliminary education of six years primary school, five years middle school and three years of the science section of a university preparatory school (Koto Gakko). Following completion of the four-year medical course in these schools, issuance of the license to practice medicine was automatic, without further qualifying examination.

Concurrently there existed second rate schools or technical colleges (Semmon Gakko) which accepted graduates directly from middle schools and prepared them for the practice of medicine after a four-year course of study. Ten of these second class schools were in operation in Japan prior to 1938, but during the war years they were rapidly expanded until at the time of surrender 51 such schools were training students for the practice of medicine. Nineteen, operated by the national government, were attached to national universities, 19 were operated by prefectural or municipal governments and 13 were private.

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Although the medical degree granted by these technical colleges differed somewhat from that granted by the university level schools, the graduates were automatically issued a license to practice medicine upon completion of the four-year course and the license in no way limited the scope of their medical practice.

During the war with China, and later World War II, medical education was geared to wartime requirements by increasing the number of medical technical colleges, resulting in an increase of the number of doctors being graduated from these schools. Prior to 1939 only 36.7% of the medical graduates were from the 10 technical colleges (Semmon Gakko). In 1945, 61.2% of the nation's medical graduates came from these schools. If this system had been permitted to continue, it is estimated that by 1949, 76.4% of the approximate 8,870 annual graduates would have received a very inferior quality of medical training.

This looseness of medical education standards allowed a great number of entirely unqualified persons to engage in the practice of medicine in Japan during and immediately preceding the war years.

A small group of approximately 60 doctors trained in European and American medical schools had always formed the nucleus of the more highly trained professional men and, until the nation was isolated during World War II, these men were able to keep abreast of modern developments in the field of medical research and education. However, here again the predominating influence came from Germany, which source had deteriorated greatly during the 10 years prior to the war.

In August 1945 there were 47,798 doctors in Japan, including those engaged as instructors and in research.

The Council on Medical Education

Japan lacked an agency willing and competent to undertake the reorganization of the medical educational system. The Japanese Medical Association evidenced no interest in such matters; therefore, it was necessary to form a group of Japanese doctors known to possess progressive ideas and representing the leading medical universities of the nation.

A series of conferences during February and March 1946 brought forth many ideas and served to identify competent educators who were incorporated into a formal organization known as the Japanese Council on Medical Education. The Council has since met in regular monthly sessions and its proposed reforms and recommendations under Public Health and Welfare Section's guidance have aided immeasurably in the development of a program leading to an effective reorganization of the medical education system.

The reformation and reorganization of the Japan Medical Association having been accomplished, the Council on Medical Education has been absorbed into this representative medical group and now functions in advising the association as well as the Ministry of Education

regarding future changes in medical educational requirements through the Japan Educational Reform Council. The Council also has representation on the Accreditation Committee of the Ministry of Education, which assures the medical association a voice in the accreditation of medical schools.

Educational Reforms

In 1947 the 51 medical technical colleges (Semmon Gakko) were carefully inspected and classified into class A and B schools. The classification "A" was given to those schools possessing equipment and faculty of sufficiently high standard to warrant consideration as university level schools, either immediately or at a later date. Class "B" were those schools which failed to meet requirements; six such schools being closed. The remaining 45 were put on probation, for it was realized that in adopting the educational reforms, students currently enrolled in the medical technical colleges would have their education abruptly halted if immediately forced to meet the new educational requirements, which required two years of university level pre-medical education and four years of medical school training in a university type medical school, following completion of primary school and secondary school, totalling 12 years. Therefore, it was agreed that the complete adoption of this program would not be effected until 1952. Of the 45 class A Semmon Gakko, 27 have already been raised to temporary universities (Daigaku) pending final approval by the Accreditation Committee of the Ministry of Education. These schools, though actually on probation, are authorized to receive new students who qualify under the new educational system.

At present in Japan there are 18 old established university medical schools, 27 temporary university type medical schools and 18 class A technical colleges (Semmon Gakko) attached to the 18 universities, a total of 63 medical schools. After 1952 the 18 technical schools (Semmon Gakko), which were allowed to exist because of their connection with universities, will be closed and Japan will have 45 medical schools, all of which are university level.

The new medical curriculum, as adopted, places emphasis on practical methods of instruction, including demonstration, experiments in laboratories, anatomical dissection and attendance at autopsies. Particular care is devoted to the practical instruction of students at the bedside and in dispensaries. Forty-seven percent of the required hours are devoted to the teaching of pre-clinical subjects, with a preponderance of these hours devoted to practical laboratory work. The distribution of time allotted to the various pre-clinical courses compares favorably with that recommended by the Council on Medical Education of the American Medical Association. Fifty-three percent of the total medical school curriculum is devoted to clinical teaching and lectures are utilized primarily to supplement the clinical instruction. Because of the increase in the number of medical schools over that existing prior to 1939, and the limited teaching facilities, 40 to 80 students per class are accommodated, depending upon the capacity of the school.

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An interim program was established which required one-year pre-medical schooling for the 1947-48 school term before entering upon the four-year medical course of a university level, followed by one year of rotating internship. For the 1948-49 period, two years of pre-medical education at university level were required prior to entrance to the four-year medical course. Although in 1950 the two-year pre-medical requirement is to continue, three years of pre-medical preparation are recommended. All medical school graduates must now spend one year in intern training in an approved hospital in order to qualify for the National Licensure Examination.

While many hospitals are sub-standard, hospital reforms are slowly progressing and great care is being exercised in selecting institutions that can provide good practical medical instruction for intern training. Hospital reform is, therefore, vital to the effective clinical teaching of medicine.

Students currently enrolled in class A Semmon Gakko will be permitted to graduate, but will be required to have one additional year of schooling at university level, plus one year internship to qualify for the National Licensure Examination. Students who were enrolled in class B schools were integrated into class A schools, one year behind their current class, and will qualify for the national examinations as prescribed for class A Semmon Gakko.

SCAP policy now provides an additional means of developing Japanese medical education by permitting Japanese travel abroad for specialized cultural and educational purposes, subject to a sponsor who guarantees all expenses and financial support. The Rockefeller Foundation is currently sponsoring two Japanese doctors for one year graduate work in public health; one at Harvard University School of Public Health and the other at Johns Hopkins University.

Under the financial sponsorship of the Earnest Sommers Foundation, one Japanese medical scientist has already visited the United States to present a series of three professional papers on his research on cancer virus. Other institutions and agencies have expressed a desire to sponsor qualified doctors and it is anticipated that increasing numbers of Japanese will benefit from these opportunities.

The Japan Medical Association

Reorganization of the Japan Medical Association along democratic lines, with removal of all governmental influence, resulted in the adoption of a new constitution on 31 August 1947, patterned somewhat after the American Medical Association. Temporary officers were elected to hold office until 9 March 1948, when the first national election was held.

The new society is dedicated to promote medical ethics, to improve and propagate medical knowledge and techniques, and to advance public health as a means of improving the social welfare.

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Membership, voluntary for those individuals who meet the professional and ethical standards required, is now being sought by the general practitioners as well as by medical scientists. Previously, medical educators and researchers were rarely affiliated with the association which is now regarded as a representative body of all physicians in Japan, regardless of their spheres of activity.

Prefectural and local associations have been formed under constitutions patterned after the national organization.

The reorganization now completed, efforts are being directed toward counselling and guiding the new association to permit its recognition among similar associations of other nations.

Medical Licensure

National examinations, inaugurated by SCAP, to obtain a license for the practice of medicine, were held for the first time in Japan in April 1947.

The Ministry of Welfare established a governing body of physicians known as the Council on Examinations for Medical Licensure, which, in turn, yearly elects a committee of 17 examiners from among the leaders in various medical fields.

The examining committee prepares and conducts national examinations, which have been held at six-month intervals to date (October 1947, April 1948, October 1948). Students who fail to qualify for licensure are permitted to retake the next scheduled examination.

The Council on Examinations for Medical Licensure establishes the policy for each national examination and supervises the work of the examining committee.

In the last examination, conducted in October 1948, 754 out of 1,996 applicants, or 37.7%, failed to qualify for licensure, principally due to failures in pre-clinical subjects. The examinations cover a four-day period and require approximately 20 hours of written tests. Somewhat rigid and with a high percentage of failures, the examinations permit only qualified persons to obtain licenses to practice medicine.

As of December 1948 there is a total of 68,820 doctors in Japan, including those engaged in teaching and research. The large increase over the 47,798 reported in 1945 is due to the repatriation of thousands of Army and civilian doctors in addition to those qualifying for licensure at the regular semi-annual national examinations.

The Medical Examiner System

Early in the occupation exaggerated Japanese press and radio reports on causes of death, attributed to starvation, among cadavers

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found on Tokyo streets resulted in the Tokyo Metropolitan Health Bureau being instructed to conduct autopsies on each body at the Tokyo University Medical School.

The system, placed in effect on 24 November 1945, quickly determined the truth of the situation in that the deaths were all caused by disease. In April 1946 a revised system was instituted covering all deaths having public health importance. This proved of such value that it was extended to include all the large metropolitan areas in Japan. By September the examiner system was operating in Tokyo, Osaka, Yokohama, Kyoto, Nagoya and Kobe.

There being no legal authority for the conducting of autopsies, the Japanese Government was directed in December 1946 to establish medical examiners offices in the principal cities of the nation. A subsequent law provided for the appointment of a chief medical examiner, who is a physician and a pathologist, to conduct all post mortem examinations of persons dying by criminal violence or neglect, accidental injury, suicide, suddenly when in apparent good health, when unattended by a physician, in prison, or in any suspicious or unusual manner.

The use of cadavers for teaching anatomy was illegal. Under this new law, bodies that remain unclaimed in the possession of the medical examiner for 48 hours may, for the purpose of advancing medical knowledge, be surrendered on request to the head of a recognized medical school. It requires the chief medical examiner to keep full and complete records, properly indexed, and to submit a monthly report of his findings to Military Government authorities.

New Legislation

The problem of regulating some 250 separate, questionable quasi-medical practices in Japan has been partially solved by the passage of a law which eliminates all but the practice of moxocautery and acupuncture, massage and judo-bonesetting. Included in the Ministry of Welfare ordinance based upon this law are rigid educational prerequisites and standards for authorized schools which, in time, will greatly limit, if not eliminate, these long-established practices.

The National Medical Treatment Act of 1942 which included physicians, dentists, nurses and pharmacists, has been replaced by four separate laws passed in July 1948, one covering medical practitioners. This provides for educational requirements, licensure, etc., as outlined in the preceding paragraphs under Medical Education.

Medical Literature

The international exchange of medical text books, journals and research data had ceased in 1939 resulting in a stagnation of normal

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educational development. Early in the occupation the great need for modern medical literature was recognized; however, as Japanese currency is not permitted as a medium of exchange outside Japan, subscriptions to foreign medical journals and publications were not possible.

The situation was partially alleviated by loans and donations from the Surgeon General's Office, Washington, D. C. Medical textbooks and other medical publications were furnished each Military Government team and made available on loan to Japanese doctors in the prefectures.

The demand, however, far exceeded the amount of literature made available. Finally, after two years of effort and in conjunction with the Civil Information and Education Section of SCAP, arrangements were completed in which republication rights of certain American medical textbooks and journals would be authorized Japanese publishing firms. Implementation of the program has been proceeding satisfactorily with 350 - 400 selected textbooks recommended for publication.

In June 1948 postal regulations were revised to permit American and other nationals to mail books and journals, as well as subscriptions, direct to Japanese Nationals through the international mails. Considerable interest has been evidenced by individuals and organizations in the United States, especially former members of the Occupation Forces, who are sending gift books and journals in increasing numbers.

The Army Medical Library, Washington, D. C., became interested in the medical literature program and shipped to Japan a number of library duplicates, some fairly modern, which have been turned over to the Japan Medical Library Association, an organization composed of medical school library representatives, formed for the purpose of effecting an interchange of literature on a loan basis. The library also sent a representative to Japan in July 1948 who completed plans for the restoration of the international exchange of medical literature.

Medical libraries have been established in the National Institute of Health and the Institute of Public Health and receive contributions of journals from the library of the Public Health and Welfare Section.

The Japan Medical Association began monthly publication of its journal in January 1947. In addition, permission was received from the American Medical Association for the monthly publication of a Japanese edition of the Journal of the American Medical Association, the first issue appearing in August 1948. The Japan Dental Association established a journal as a monthly publication in November 1948.

An exchange of journals has also been established between the Japan Medical Association and several United States medical societies.

Future programs provide for continuous supervision to bring the current medical literature plans to a successful conclusion and determine that proper distribution is made of all material as it becomes available.

It is also planned to establish a post-graduate medical education program and to elevate the educational and professional standards of

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the services closely allied with medicine, such as X-ray technicians, laboratory technicians, physiotherapists, etc.

Endowments by private individuals and organizations for the establishment of medical scholarships and medical foundations will also be encouraged.

Another future program is a proposed redistribution of doctors in Japan so that rural districts are provided with medical service. A survey is now being conducted by the Ministry of Welfare toward this end.

Continuous surveillance will be exercised over all reforms and projects to observe that, as they near completion, they will be adaptable to the future Japanese economy.

Hospitals, Leprosaria and Sanatoria

Concentration of the nation's efforts in meeting military requirements during World War II similarly had its effect on the physical deterioration of hospitals and other medical institutions. One thousand twenty-seven hospitals, with a total bed capacity of 53,000 were destroyed as the result of war. Large quantities of heating and central cooking equipment had been removed from all hospitals for use as scrap metal. Military medical installations held large quantities of drugs and medical equipment, depriving the civil population of urgently needed medical supplies. Many hospitals had been without X-ray film for at least three years, were unable to procure adequate amounts of drugs, and also found it necessary to wash and reuse dressings.

All Japanese hospitals were "closed" institutions with a paid staff of doctors. Most Japanese civilians received medical care by going to hospitals rather than to the doctor's office, as is common in the United States. Therefore, all hospitals had large out-patient services from which in-patients were obtained for the hospitals. The private practitioner who had no connection with the hospital staff found it necessary to provide some measures in which he could retain the care of his patients. As a result, thousands of inferior grade hospitals of ten beds or less were established by private practitioners to Hospitalize their own patients.

Surveys determined that physical facilities of hospitals of more than ten beds, although suffering heavy damage, existed in sufficient numbers to provide adequate hospital beds for the needs of the civilian population, but the lack of equipment, supplies and competent personnel resulted in these institutions operating in a very sub-standard manner. The poor medical service being rendered, plus the fact that hospitals could not provide ample food for their patients, resulted in a small percentage of the available beds being occupied.

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National Hospitals Established

There were 320 army and navy hospitals, with approximately 78,000 patients in operation at the time of surrender. These institutions were turned over to the Home Ministry, then later transferred to the control of the Ministry of Welfare and re-established as national hospitals. The national hospitals located at ports of entry were utilized to process repatriates.

Preferential treatment to military patients was discontinued and all national hospitals were required to render services that would meet the needs of the civilian community. Although a large number of military patients still require hospitalization, approximately 70% of the total patients currently hospitalized are civilians.

The Ministry of Welfare is currently operating 98 national hospitals, with 18 branch hospitals, making a total of 116 national general hospitals with a bed capacity of 28,118. Of these beds, 6,334 are devoted to the treatment of tuberculosis. In addition, the national government operates 143 tuberculosis sanatoria with a bed capacity of 33,001; 10 leprosaria with 7,988 beds; two mental hospitals with 675 beds; one hospital for head injuries, with 180 beds; one hospital for spinal cord injuries, with 100 beds, and seven hot springs hospitals with 861 beds.

Career officers of the Japanese Army and Navy who formerly made up the majority of the professional employees of national hospitals and sanatoria have, as of 1 May 1948, been completely eliminated. The staffs of these institutions, numbering 2,799 physicians, are now 100% civilian with no former military affiliations. A favorable ratio of one physician to every 26 patients now exists.

All the national hospitals are now "open" hospitals wherein qualified practicing physicians are permitted to continue treatment of their hospitalized patients.

Bed Status Reporting

Early in the occupation a weekly reporting system, by prefecture, was established, which included the number of beds available and beds occupied and the number of out-patients treated. This report included all hospitals of more than 10-bed capacity, other than tuberculosis sanatoria, mental hospitals and leprosaria. With the passage of the Medical Service Law, requiring an institution to have a capacity of at least 20 beds before being classified as a hospital, this statistical report was revised to include all classes of hospitals in Japan of 20 beds or more, the data to be reported on a monthly basis.

There are at present 2,852 hospitals, including national hospitals, of 20-bed or more capacity in operation in Japan, with a total of 244,709 beds. This provides one bed for approximately each 328 persons. The latest report, December 1948, indicates that there was an average

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daily occupancy of 132,178 beds. An average of 257,258 daily outpatient treatment were given during the month of December 1948, which reflects the yearly daily average. (Ref. chart 18).

Hospital Administration

Changes in the operation of Japanese hospitals, to raise the standards of treatment to modern levels, are underway. Such changes are so interwoven with the medical education program, the nursing education programs, the availability of qualified physicians, medical investigators, plus hospital administrators, that improvement in hospital administration will not take place rapidly. Considerable progress has been made in providing nursing care for patients, in establishing central kitchens, securing increased rations, and improving general sanitary conditions. The age-old Japanese custom of permitting relatives to live in the same room with the hospital patient, preparing meals and providing nursing care, is being eliminated by establishing central kitchens and regular visiting hours.

An early recognized reform was the need to eliminate the small hospitals of ten beds or less, where it was known that inferior medical practices existed. In July 1948 the Diet passed the Medical Service Law which provides a legal basis for hospital standards. Under this law, small independent hospitals may continue to exist as clinics where minor surgical conditions or simple diseases may be treated, but no patients may be confined more than 48 hours unless an emergency exists in which case the approval of the local health officer must be obtained.

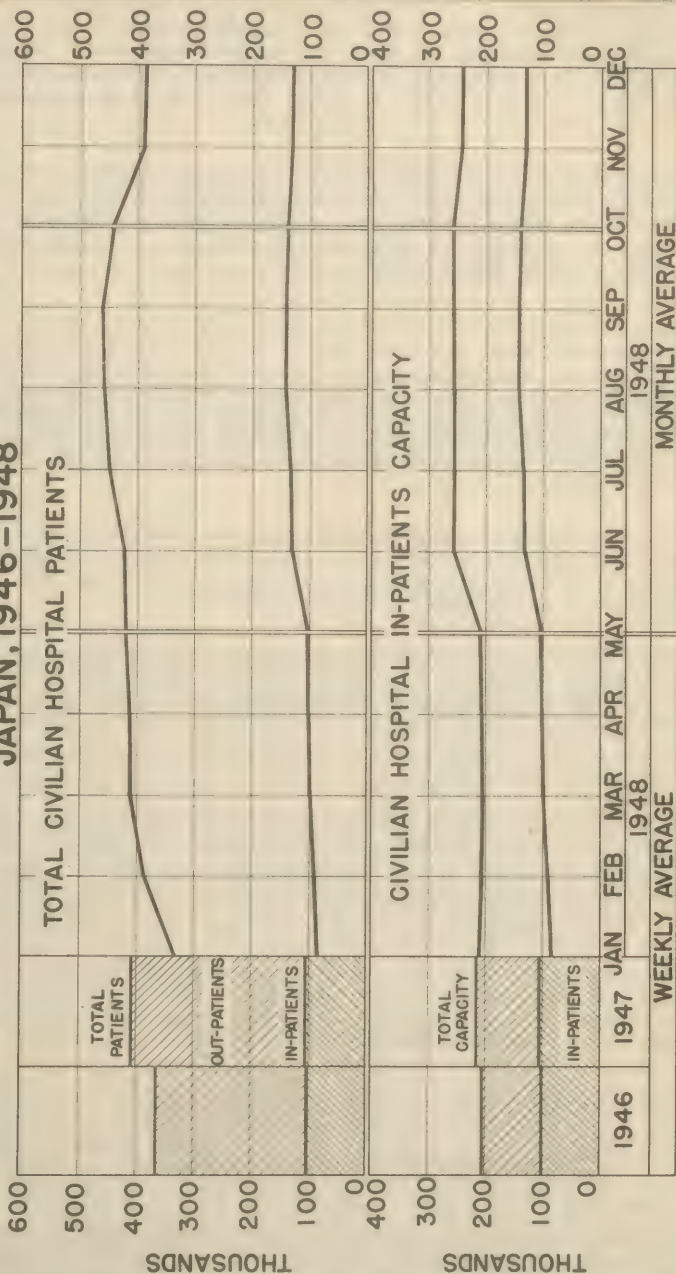
The law further stipulates that a minimum of 20 beds must be available to obtain hospital classification. It provides for the regulating of medical fees in public hospitals, sets forth minimum hospital standards, provides an inspection system for hospitals and recognizes government grant-in-aid to public institution facilities for purposes of construction, repair or addition, but not for operational activities. This new law is a major forward step in hospital reform.

The lack of competent hospital administrators in Japan is a delaying factor to more rapid progress in hospital improvement. The Ministry of Welfare recently established a committee, under SCAP guidance, to study this problem and provide for faculty, curriculum and teaching facilities. The committee recommended that one of the national hospitals be developed as a model hospital and that facilities be provided within this hospital for the practical training of administrators. The first class began in September 1948, with 30 directors of national hospitals enrolled in an initial course of two weeks' duration. In all, 200 students, directors and business managers of national institutions have received this short period of training. A two-month course in hospital administration will shortly be established and made available to directors of public and private hospitals.

The First National Hospital in Tokyo was selected as the national hospital to be developed into a modern model institution. Plans have

CIVILIAN HOSPITAL PATIENTS

JAPAN, 1946-1948



HOSPITALS HAVING 10 BEDS OR MORE, EXCLUSIVE OF T. B. SANATORIA AND LEPROSARIA 1946-1947 AND JAN-MAY, 1948
HOSPITALS HAVING 10 BEDS OR MORE, INCLUSIVE OF T. B. SANATORIA AND LEPROSARIA JUN.-OCT. 1948
HOSPITALS HAVING 20 BEDS OR MORE, INCLUSIVE OF T. B. SANATORIA AND LEPROSARIA NOV.-DEC. 1948

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been completed for this conversion and construction has begun. The development of this hospital has been determined as the first project leading to the establishment of a national medical center. The hospital will serve as a model for the development of other modern hospitals throughout Japan, and is the first step in a plan creating at least one model hospital in each prefecture.

The completion of the model hospital and the opening of the extended hospital administrators training course is an important objective which will be closely supervised. A plan for the education and rehabilitation of patients in tuberculosis sanatoria, many of whom are of school age, is also under study.

Dental Affairs

During the war all dental activity had completely collapsed. Out of 140 dental equipment and material manufacturers, only 11 remained in existence after the war. Fortunately, these 11 firms were the largest producers and subsequently managed to maintain production at about 50% of the pre-war rate.

Eight dental schools remained after the war, one being operated by the National Government, one by a prefectural government and the remaining six by private corporations. Only three of these schools had escaped damage by air raids.

Most all clinical and laboratory equipment had deteriorated or was appropriated for scrap metal; gas, water and electricity had been stopped or reduced as a result of destruction to these facilities. Nearly 6,000 private dental clinics were destroyed by air raids. All dental hygiene in public schools had ceased due to the shortage of dentists and dental materials.

Many faculty members and students had joined the military services and the remainder worked part-time in factories or on farms. Courses were shortened and revised to produce more dentists for the armed forces. The German language was used in teaching and was also utilized in the instruction system.

An examination for licensure was not required of practitioners; consequently, professional standards were low. This also applied to dental hygienists. The Japan Dental Association was a quasi-governmental organization with compulsory membership amounting to some 20,000 members.

The Council on Dental Education

The Council on Dental Education was established early in the occupation to recommend educational reforms. One of the first steps taken was the release, on a quarterly basis, of precious metals for dental purposes, which was approved by the Reparations Commission.

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Three years were added to preliminary schooling as a requirement for entry into dental college. The entire dental school curriculum was revised, assigning appropriate hours to subjects according to their importance, eliminating those considered irrelevant and adding new necessary subjects. Laws were passed which established university level standards for all dental schools.

These educational reforms became known as the 6-3-3-2-4 plan (1946) of dental education and consisted of six years of primary school, three years of lower secondary school, three years of upper secondary school, two years of pre-dental schooling at university level, followed by four years at an approved dental college.

The Council on Dental Education also was instrumental in establishing the National Board of Dental Examiners whose responsibility is to prepare and conduct the national examinations for dental licensure. These examinations, conducted every six months, began in April 1947. Approximately 3,000 students have qualified for the three examinations to date, with 70% having been granted a license to practice dentistry. Those who fail are permitted to retake the next scheduled examination.

The Japan Dental Association

Organization of a new Japan Dental Association, divorced from government control and influence, was finally accomplished by law on 1 November 1947 which dissolved the old association at the same time.

Adoption of a new constitution and the first national election of officers under democratic methods was held on 25 March 1948. Throughout Japan all prefectural and local groups have now formed similar new societies, based on the national constitution.

The present association, although new, is making steady progress and is being given all necessary counsel and guidance to permit its recognition among dental associations of other nations.

Educational Progress

Educational reforms have been making steady progress. In 1946 two dental schools were granted university standing permitting them to accept pre-dental students under the 6-3-3-2-4 plan. Three more schools attained this status in 1947, leaving three of the original eight who have not as yet met the new standards. In order to determine that dental schools are meeting the standards set by the Council on Dental Education, the Ministry of Education appointed a board of school inspectors who periodically check on the schools granted university standing.

The first group of students to enroll under the present two-year pre-dental and four-year dental course at university level will graduate

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in 1952. They should be more advanced and more capable dentists. In the meantime, students who were pursuing courses when the new plan was placed into effect, will be permitted to graduate without additional schooling, but are required to pass the national examination successfully.

An important part in the educational program has been the regular monthly meetings of the faculties of all schools in which each basic and dental subject in the curriculum is discussed in order to improve teaching methods.

Another significant step was the dissolution of the war-time Dental Materials Control Company and the restoration of free trade on dental items, with the exception of precious metals.

Rehabilitation of the bombed-out dentists has progressed until currently 90% of the original 6,000 have been re-established in practice. A total of 26,277 dentists are now engaged in the practice of dentistry in Japan.

In connection with the nation-wide health center program, a short intensive course to train public health nurses to function as oral hygienists in the health centers was completed in April 1948. Additional courses are being planned.

An active dental health educational program among the civil population is now in progress. Motion pictures and short radio talks on oral hygiene have been presented throughout the nation. Dental hygiene has been re-established in the schools on a more practical basis, with many volunteer dentists traveling to rural areas for the purpose of conducting examinations and lectures. A recent oral hygiene essay contest conducted in Tokyo and Osaka resulted in 230,000 entries being received, demonstrating the interest that is being stimulated by this program.

The Public Health Train, which completed a nation-wide tour of Japan in August 1948, carried a complete dental exhibit including moving pictures on oral hygiene subjects produced by the American Dental Association. Complete mobile dental clinics, modeled after U.S. Army mobile dental clinics, are being placed in operation for use in outlying school districts. Two such clinics are currently in operation.

A national caries program, conducted from 1 - 10 June 1948, provided free clinical examination to all individuals who applied for such service. In Tokyo, the erection of street booths, as an aid in conducting examinations on passers-by, created unusual public interest during this 10-day period.

Further advancement in elevating dental school standards was made on 1 July 1948 with the formation of the Japan Association of Dental Schools. Organized to foster and coordinate ideas of mutual interest, this association will be an important factor in overall educational reforms.

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In the field of literature, the first increment of dental text books has been revised and rewritten and is currently being printed. Donations and subscriptions from dental associations in the United States, now arriving in increasing quantities due to revised international mail regulations, will augment the limited dental literature supply.

Based on recommendations made by the Council on Dental Education, the Dentists Law and the Dental Hygienists Law, passed by the Diet on 4 July 1948, provide a legal basis for the programs now in effect. In addition, the Medical Service Law, passed by the Diet on the same date, carried certain provisions relative to the operation of private dental clinics and dental clinics operated in conjunction with hospitals.

All dental programs have been well established by law. Necessary supervision and guidance will continue to be exercised to determine that satisfactory results are being attained. Of particular importance, however, is the expansion of dental service to all the planned 800 nation-wide health centers. This is a long-range project which can be completed only as personnel, materials and funds become available.

Chapter 4

NURSING ACTIVITIES

While other professional groups and associations concerned with public health and welfare problems of the nation suffered from lack of adequate standards, plus the resultant destruction and deterioration caused by war, the fate of Japanese nursing programs was even less fortunate. Prior to World War II there had been a slight trend toward standardization, but even this failed during the war years.

Japanese nurses had never received professional recognition. Three separate nursing associations existed under government control and influence, namely the Japanese Midwives Association, the Japanese Nurses Association and the Japanese Public Health Nurses Association, all of which functioned independently of each other. Officers of all the associations were men, nurses and midwives having no voice in management.

During the war, nursing education was accelerated to provide personnel for the armed forces. Students were admitted to schools of nursing at an age younger than 18 years and courses were shortened to one or two years. Standards of education, registration and organization had many variations. Approximately 34,000 nurses were absorbed by the armed forces and, as they were of the more qualified group, this resulted in a depletion of trained personnel for the civilian population.

There were a total of 39,727 clinical, public health and midwifery student nurses in training at the time of surrender. Graduates numbered 166,341 with 605 training schools being listed.

The majority of the graduates were primarily engaged in midwifery and nursing. Few hospitals were utilizing nursing services and the institutions that had nurses on their payrolls were using them primarily for cleaning and scrubbing activities. Most of the public health and clinical nurses were working for various insurance associations, prefectural and local health bureaus and for private corporations. Nursing services, as exists in modern nations, were hardly known to the Japanese profession except in a few minor instances. The St. Luke's Hospital in Tokyo, built with funds donated by the Episcopal Mission of the United States and partially staffed by American personnel, maintained a nursing program comparable to an average modern class A hospital and produced qualified graduates. Throughout the nation, however, nursing activities had fallen to a very low standard at the time of surrender.

The Nursing Education Council

An over-all survey of existing schools of nursing and available nursing personnel was organized under the supervision of SCAP. The

organization included representatives from the Ministries of Welfare and Education, the Clinical Nurses Association, the Public Health Nurses Association, the Midwives Association, and leaders from various schools of nursing in Japan in which both the large and small institutions were included. This organization became known as the Nursing Education Council and was given the responsibility of improving nursing education standards. Subsequently, committees and subcommittees were formed to study various phases of the nursing programs and to make recommendations for elevating standards and educational requirements.

Under SCAP guidance, the Council has been very active in organizing a modern nationwide nursing program. Based on their recommendations with supervision and assistance from American nursing personnel, refresher and full time training courses were started, educational standards were raised and registration and licensure requirements were placed into law. The Council has been an important factor in the results accomplished to date.

Demonstration Schools of Nursing

The Nursing Education Council proposed that a model demonstration school of nursing be established to raise nursing standards and train leaders for modern nursing requirements. On 1 June 1946, a school was opened in the Central Red Cross Hospital in Tokyo and became known as the Tokyo Model Demonstration School of Nursing.

Students from the St. Luke's College of Nursing and the Central Red Cross Hospital were merged into one student body, totaling 420 trainees. The faculties of both schools were utilized in addition to a staff of four American nurses who supervised and assisted in the teaching programs.

Modern three year courses in clinical nursing are being given with the initial full term class scheduled for graduation in June 1949. Requirements for students that were currently enrolled were changed to conform to new educational standards consisting of revised curriculum, improved textbooks and literature and more practical training in out-patient, surgical and other departments.

In the fall of 1946, the demonstration school was granted recognition as a College of Nursing by the Ministry of Education, retroactive to June 1946. This was an important step in that the Japanese became cognizant of the value of this program.

Two classes have now graduated (March 1947, March 1948) and two new classes have entered school for the regular three year course. Current enrollment is 280 students.

The school has made commendable progress. An undergraduate public health course has been added and all senior students receive lectures and field work. The staff compiled, translated and published their own nursing procedure manual. Enthusiasm displayed by the students for the opportunity of acquiring a modern nursing education and their cooperation in all the activities associated with the

school has played a large part in the over-all results attained.

On 1 May 1948 a second model demonstration school of nursing providing a three year course in clinical nursing was opened at the Okayama National Hospital in Okayama City. The staff consisted only of graduates as no school of nursing had existed here for several years. Due to limited classroom and teaching facilities only 40 students could be accommodated for the initial class, made up of 10 selected applicants from each of the four neighboring prefectures.

Concurrently, in the same hospital Public Health and Welfare Section nursing personnel supervise a two-months refresher course for the 45 graduate staff nurses who were selected to teach the new students. Two short clinical nursing refresher courses were also given by the Military Government Regional Public Health Nurse with the staff's assistance.

Plans are progressing to expand classroom facilities and obtain additional instructors, thereby permitting a larger quota of students for the class starting April 1949. Many doctors and nurses have visited the hospital to inspect the facilities and to study the nursing program in effect and a number of business clerks have been sent to study the system of hospital administration. This demonstration school of nursing not only fulfills the need for teaching modern nursing education in the neighboring prefectures, but also the adjoining areas of Honshu and Shikoku.

On 15 May 1948, a third demonstration school of nursing was opened at the First National Hospital in Tokyo. This hospital had previously been selected as a model demonstration hospital, work currently progressing towards a complete realization of this project. (Ref. Chapter 3, MEDICAL CARE)

Classroom and dormitory facilities and equipment have been provided to permit acceptance of the maximum of 60 applicants authorized by a law establishing this program and who are scheduled to begin the three-year clinical nurses course in April 1949.

In the meantime, under the supervision of PH&W nursing personnel, the 226 graduate staff nurses of the hospital have been divided into groups for three-month in-service training and refresher courses in preparation for the work they will assume in the nursing program. Four staff members, qualified as full time instructors, are being given additional training at the demonstration school of nursing at the Central Red Cross Hospital. Other staff members, qualified as regular part time instructors and nursing leaders, are receiving direct supervision during the refresher courses.

Refresher Courses

Many types of refresher courses have been given since the nursing program started. All have contributed to improved nursing services and advancements in nursing education. American nursing personnel have assisted in teaching these courses but as more and more Japanese nurses become qualified as instructors American nurses have confined their activities to supervision and guidance.

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A four month refresher course for public health nurses was opened at the Institute of Public Health in Tokyo on 2 April 1947. These courses have continued to date as the original plan provide for 730 nurses to be trained in groups of 50 per class. Nurses receiving certificates from this course will be used to staff health centers and prefectural and local departments of health. Intensive didactic work and practical field experience is included in the curriculum, the field experience being obtained in six selected health centers in Tokyo and nearby prefectures. To date, 330 nurses have completed this course.

To prepare the nursing personnel of the model health centers for their responsibility of supervising this part of the health center program, American nursing personnel conducted a thirty-day refresher course which began in February 1947. Twenty-five nurses were given 96 hours of classroom work and demonstration techniques during this period. In June a similar ten-day course was held at the Institute of Public Health for nurses who were assigned to work in the health centers. Ninety-nine nurses from 46 prefectures attended this course.

The Japanese National Tuberculosis Association sponsored a six-month refresher course in tuberculosis nursing which was completed in June 1947. Certificates were awarded to 24 nurses. This course, shortened to five months, was again repeated in November 1947 and in April and August 1948. The fifth such course is currently being held.

The nurses selected for these courses are given didactic work and practical experience working with tuberculosis patients in sanatoriums, clinics, and private homes. The schedules and subjects taught have been carefully planned in order to be assured that up-to-date material is furnished the students.

In addition to the refresher courses enumerated in the preceding paragraphs, a clinical nursing refresher course of six weeks duration was held at the Nippon Medical University, Tokyo, during September and October of 1947. This course, attended by 60 nurses, was given to aid the clinical nurse personnel meet the new standards required by recent nursing legislation.

In October 1947, the Midwifery Section of Tokyo-to sponsored a short course of 30 hours for midwives at the Keio University Hospital. Outstanding Japanese obstetricians and pediatricians conducted the lectures which were attended by 84 midwives.

The National Nurses Association sponsored a three-week refresher course for public health nurses, clinical nurses and midwives in Fukushima Prefecture during November 1947. Six surrounding prefectures coordinated in sending 150 nurses to this demonstration.

Sponsored by the Educational Committee of the National Nurses Association a series of one-month institutes were started in the early part of 1947. These courses consisted of lectures and demonstrations to both instructors and students of colleges of nursing affiliated with a recognized hospital. During the summer of 1947, two institutes called "Summer School for Nurses and Midwives" were held in Osaka and Hokkaido respectively.

The Ministry of Welfare and the Public Health Section of the

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National Nurses Association sponsored a national refresher course for public health nurses. The course, given in eight regions and attended by 864 nurses, was under the guidance of the public health nursing consultant, the Educational Committee of the Public Health Nursing Section of the Association and the Military Government nurses. The functions of the public health nurse and demonstrations of public health nursing technique were emphasized.

The Educational Committee of the Tokyo Branch of the National Nurses Association sponsored a 20-day refresher course in January 1948 for the general staff nurses on duty in Tokyo hospitals.

In March and April 1948 an intensive two-month study course for nursing instructors was held in the Central Red Cross Hospital in Tokyo. Sponsored jointly by the Ministry of Welfare and the National Nurses Association, 52 prefectural nursing leaders received certificates of completion. The responsibility of the instructor to the students in training and advanced teaching techniques were carefully demonstrated during this period.

The Ministry of Welfare and the Midwifery Section of the National Nurses Association together sponsored ten-day midwifery refresher courses which were conducted in each of the 10 larger cities in Japan. The lectures were conducted by midwifery consultants and covered the entire care of mother and baby, the responsibility of the midwife and the midwifery nursing program. These courses, conducted from March to October 1948, were attended by 1856 midwives.

A four month refresher course for clinical nursing instructors, sponsored by the Ministry of Welfare, was held at the Central Red Cross Hospital in Tokyo from August through November 1948. The curriculum for this course included 512 hours of nursing arts, education, administration, professional relationships and practice teaching. Each prefectural nursing representative, 46 in all, received certificates of completion.

These refresher courses, given to all categories of nursing personnel, have proven invaluable in teaching the nurses modern techniques and educational requirements for the present day nurse. The interest and enthusiasm displayed by both the nursing students and graduates has been a tremendous help in advancing ideas in modern nursing education.

The National Nurses Association

It was recognized early in the Occupation that the three Government controlled nurses associations in existence would have to be dissolved and a new organization formed on democratic principles. In November 1946, the three associations jointly held their annual meeting in Tokyo. During this meeting a group of 20 nursing and midwife leaders which had been formed as a study group to discuss the organization, function, constitution and program of a new nursing association, presented a proposal to form a national association under the name of the Japanese Midwives, Clinical Nurses and Public Health Nurses Association. It was recommended that membership be limited to actively

licensed nurses and midwives and only association members be authorized to hold office.

The assembly of approximately 1,300 nurses favorably voted to establish the new association, adopted a proposed constitution and temporarily elected officers who served until the first annual meeting in April 1947. The four months interim period gave the new association time to complete organization plans, arrange programs, incorporate the association as a juridical person and also provide an opportunity for the officers to learn the principles and practices, as well as the duties and responsibilities of holding office. During the April 1947 meeting, in which all prefectures were represented, permanent officers were elected for the ensuing two year period and various committees formed to carry out the many activities connected with the nationwide nursing program.

On 4 June 1947 the Association was registered as a juridical person and, therefore, became recognized by the Japanese Government. Freed from all government influence and control, the new association has made a steady progress during the past two years. Current active membership totals 68,773.

The Nursing Law

Regulations pertaining to nursing activities were incorporated in the National Medical Treatment Act of 1942 which also included doctors, dentists and pharmacists. This law was inadequate in all respects. Immediately following the reorganization of the National Nurses Association steps were taken to plan new laws that would meet modern nursing requirements.

On 3 July 1947 Japanese Cabinet Order No. 124 amended the National Medical Treatment Act pertaining to nurses and established standards of legal registration and licensure of clinical nurses, public health nurses and midwives. While this amendment served to fit the existing needs, the Nursing Education Council proposed that an entirely new separate nursing law be enacted.

On 30 July 1948 Law No. 203 passed the Diet providing the necessary legislation to maintain and control nursing standards and education. Applicants for schools of nursing must have at least 12 years of schooling comprising six years of primary school, three years of lower secondary school and three years of upper secondary school. The law stipulates that clinical nursing courses will be of three years duration and further, that public health nursing and midwifery programs will be on a postgraduate level with graduation from a three year clinical course required. Requirements to be met by school faculties, hospital facilities and practical experience training are also included in this law.

The law is patterned very closely after existing nursing laws in the United States and offers the Japanese nurses every legal essential in establishing a modern nursing profession.

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Nursing Affairs Section

The Nursing Affairs Section in the Ministry of Welfare was created by Cabinet Order on 23 June 1948. The Section is composed of a chief with one assistant selected from each of three branches of nursing services.

Nurses Aide Program

In January 1948 in coordination with the Surgeon's Office, Far East Command, 200 selected Japanese nurses were employed as nurses aides in the 12 United States Army hospitals in Japan. To educate them in modern nursing techniques, they were first given 160 hours of instructions and supervised ward demonstrations, then assigned to regular nurses aide duties. A qualified Japanese nurse was provided each United States Army Hospital to assist in the teaching program and also to serve as an interpreter. This program has been very successful and another training course is being planned.

Nursing Education Progress

In order to determine whether the existing schools of nursing would be able to meet the requirements of the proposed nursing law, which passed the Diet in July 1948, an extensive survey of schools of nursing, midwifery and health centers was started in April 1947. These surveys, completed in all 46 prefectures, furnished information relative to existing curricula, educational standards, physical facilities, degree of training and determined those schools that would be permitted to continue under the current nursing law. Data obtained from this survey will be used in deciding which colleges of nursing will be granted government recognition. These surveys have also been used to determine the eligibility of Japan to regain recognition in the International Council of Nurses.

In connection with the various public health refresher courses, a public health nurses box has been designed and adopted for use in the home visiting program. Diagrams of this box, a list of its contents and technique for use, has been printed in English and Japanese and distributed to all prefectures to be used as a guide for constructing similar boxes in prefectural nursing programs.

In the visual education field, a 35 mm. sound film has been made portraying Japanese nurse training and activity. Entitled "Lady of Science," the film depicts the various steps of the nurse's life while undergoing training and also shows the nurse engaging in postgraduate work after completion of a regular three year clinical course. Produced by a Japanese film company, the film has been presented in all prefectures to date and to members of the National Diet prior to passage of the nursing law. The picture has been exhibited to young people in upper secondary schools, as a means of acquainting them with nursing as a profession, as well as to doctors and nurses.

The latest complete report indicates there are 739 existing

Public Health and Welfare in Japan

schools of nursing, both public and private (including 31 schools of nursing in Japanese Red Cross Hospitals covered under Chapter 6, WELFARE), with a total enrollment of 31,953 students. Licensed graduates total 251,375.

Study Abroad

Japanese travel abroad is now permitted for the purpose of cultural or educational study; but subject to a sponsor who guarantees all financial support (Japanese citizens are not accepted as sponsors). The Rockefeller Foundation approved scholarships for four nurses for postgraduate study in nursing and public health methods and administration in four selected American universities. These nurses departed for the United States in July 1948. Other agencies and organizations in the United States have also expressed an interest in sponsoring Japanese travel for specific educational purposes and it is anticipated that in the future a larger number of Japanese nursing personnel will be given an opportunity to share in this program.

Nursing Literature

Japan's isolation from 1939 until the beginning of the Occupation, resulted in a stagnation of modern nursing text books, journals and literature. During the early phases of the nursing program most of the material used for the full time and refresher courses was composed by PH&W nursing personnel and translated and published by the Japanese. This was a rather difficult procedure due to the time consuming element and the shortage of paper. It was, therefore, realized that the securing of modern nursing material was essential to effective teaching.

The Ministry of Welfare and several qualified Japanese doctors, nurses and SCAP staff have published nursing literature including a Procedure Manual for Clinical Nurses, the Midwifery Manual, the Manual for Public Health Nurses, Standing Orders for Public Health Nurses, and have adapted and printed a Public Health Nursing Record to be used in recording home visits. A booklet entitled "We Grow Up" (United States Public Health Service Booklet No. 102) has been translated into Japanese and published for the benefit of Japanese nurses, also booklets on tuberculosis, syphilis and infant care have been published in Japanese.

Various nursing associations and agencies in the United States, who are interested in the nursing program in Japan, have donated copies of text books, journals and other nursing literature, of which 11 copies have been translated into Japanese and published and distributed to the various colleges of nursing and prefectural nursing associations. The remaining gifts are currently being translated and printed.

A recent policy now permits copyright privileges of certain American publications and it is anticipated that within the next six months selected nursing text books will be available for republication in Japanese.

Future programs provide for a continuance of all the regular three year clinical nurse courses, demonstration schools and the refresher courses, including postgraduate training, which have proven so beneficial. It is also planned to provide special courses in various hospitals to help prepare the clinical nurses in meeting the requirements of the new Nursing Law.

Particular emphasis will be placed on the attaining of scholarships for nurses to study abroad and also to obtain further quantities of modern nursing literature. The Japanese Midwives, Clinical Nurses and Public Health Nurses Association will continue to be given advisory help in preparing them for recognition among similar associations of other nations.

An important project is the securing of American public health nurses for the 46 prefectures in Japan. American nurses are now assigned to nineteen prefectural and eight regional areas, but the expansion of the nationwide nursing program makes it essential that additional American personnel be available for supervision and guidance including public health nursing activities in the nationwide health center program.

Chapter 5

VETERINARY AFFAIRS

Under the supervision of the Veterinary Section in the Horse Bureau and the Veterinary Affairs Division of the Agriculture Bureau, Japan's pre-war animal disease eradication programs consisted of Infectious Osteomalacia, Equine Paratyphus, Tuberculosis of Dairy Cattle, Sterility Control in Cattle, and Research on Equine Infectious Anemia. Control was also maintained over veterinary licensure.

During the war civilian veterinary activities were sharply curtailed as the military carried a high priority on animal disease control work being conducted on Japanese Army horses. The production of animal biologicals amounted to over 10,000,000 cc annually of which 80% were requisitioned by the Army. This created an acute shortage for non-military veterinary control.

Meat and milk inspections were carried out solely under prefectural supervision as subsidies from the national level had never been granted. Monthly inspections were made in milk plants but meat inspection was irregular consisting of an occasional visit to slaughter houses.

The emphasis on veterinary activities was placed on the maintenance of health in the horses of the Japanese Army. No Army food inspection was in force.

The Japan Veterinary Medical Association

Late in 1946 a Council on Veterinary Affairs was established and immediately began the reorganization of the Japan Veterinary Medical Association along democratic principles. New associations, likewise formed in the prefectures to promote national veterinary policies have taken a leading part in the various veterinary programs. The Council on Veterinary Affairs also plans and promotes projects under the sanction of the Japan Veterinary Medical Association that are of interest and value to the veterinary profession. This has stimulated the improvement of veterinary standards.

Officials and members of the new association have gradually accepted more responsibilities as they gain confidence in themselves. They were encouraged to publish a monthly veterinary journal and in addition have published booklets on technical subjects for use by veterinary officials.

A total of 30 prefectures have organized associations with approximately 7,000 members being registered. Membership in a prefectural association automatically confers membership in the national association.

The Veterinary Education Council

The Japan Veterinary Medical Association immediately upon being

reorganized as a juridical body, formed the Veterinary Education Council. This council, under SCAP guidance, made an exhaustive study of minimum educational standards. Based on their recommendations it was finally agreed that 12 years of preliminary education, consisting of six years primary school, three years lower secondary school, and three years upper secondary school be required prior to entrance to the new four year veterinary college course at university level. In addition the Ministry of Agriculture and Forestry approved their plan for a national examination for veterinary licensure, the initial examination to be held following the graduation of students from the 1949 class year.

Under SCAP guidance, representatives of the Council in conjunction with the Veterinary School Inspector of the Ministry of Education, made a survey of the 16 veterinary schools in Japan. As a result of this survey, recommendations were made to increase the facilities of the schools, re-establish animal clinics, and revise present curriculums to a level commensurate with those of foreign schools.

Confronted by a shortage of public health veterinarians trained in modern veterinary standards, a two-month refresher course opened at the Institute of Public Health in Tokyo on 9 January 1948. These courses have continued to date, each prefecture being allocated one representative from their public health department. The council was instrumental in organizing this refresher program and in many other ways has assisted in elevating veterinary education and standards.

The council has also been active in establishing monthly refresher schools for prefectural veterinarians engaged in animal disease control work. This action was coordinated with and under the supervision of the Ministry of Agriculture and Forestry with guidance by SCAP.

Control of Animal Diseases

After determining that civilian veterinary activities had practically ceased, the Japanese Government was directed to establish measures for the control of animal diseases, submit animal disease reports, submit reports on the manufacture of biologicals, re-establish animal quarantine stations, establish measures for the inspection of meat and dairy products, and submit reports on meat and dairy inspections including the testing of dairy cattle for tuberculosis.

An amendment to Law No. 29, The Prevention of Infectious Disease of Domestic Animals, was passed by the Diet on 29 June 1948 and became effective on 20 July 1948. This amendment requires the reporting of all infectious diseases, pays an indemnity not exceeding ¥ 30,000 when animals are removed for slaughter during disease prevention programs, and requires a health certificate to accompany all animals intended for breeding purposes when shipped between prefectures. Regulations implementing this law have been adopted and in addition include those programs concerned with the eradication of Bovine Tuberculosis and Equine Infectious Anemia.

Tuberculosis tests were completed on two-thirds of the dairy cows available for testing during each year of the occupation and in the summer of 1948, a general trend of substituting the intradermal test for

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the subcutaneous test was effected as a means of increasing the efficiency of the program and removing all doubts as to the effectiveness of the old test. This has resulted in additional numbers of positive reactors being found over and above the number normally reported in the past. At the same time owners of reactors are cooperating more fully in removing reactors for slaughter, for in the past, segregation of the tubercular animal was ineffectively carried out due to poor supervision over such cases.

Recommendations to the Ministry of Agriculture and Forestry were made to re-establish or inaugurate research programs on those diseases currently inflicting losses to the livestock industry. The diseases which are essential in the research program are Foals Disease, Winter Encephalitis, Equine Encephalomyelitis, Equine Infectious Anemia, Brucellosis, Trichomonas, Vibrio Foetus, Equine Paratyphus, Canine Distemper, Newcastle Disease of Fowls and Pullorum Disease of Fowls.

These programs continued through 1947 and 1948 and with the exception of Foals Disease and Equine Encephalomyelitis, all outbreaks of animal diseases were controlled. Emphasis is being placed on an acceleration of activity on the part of all Animal Hygiene Experimental Stations in setting up programs to eliminate these diseases from the breeding stock.

Steps were taken to resume the manufacture of biologicals (for animal use) and other veterinary supplies. Effective control measures were adopted in the production of biologicals through improvement and restriction for utilization until assayed. Competence was given the Ministry of Agriculture and Forestry under the Pharmaceutical Affairs Law No. 197, 30 June 1948 to establish controls over all drugs and biologicals intended only for use in animals. As a result of such action, improvements in the manufacture of biologicals have been made as well as increases in production to a level commensurate with the demand. Production was so successful that some export of biologicals became possible.

Animal quarantine stations were reorganized, additional personnel assigned, and facilities improved to adequately handle animals for export and import and conduct laboratory tests on animals during the quarantine period.

In the fall of 1947 several regional conferences, attended by officials from the Ministry of Agriculture and Forestry, resulted in the completion of an emergency plan should disease potentials suddenly reach epidemic proportions or new disease entities be encountered in relation to imports which would require the application of effective control measures.

On 12 July 1948, Law No. 140, Processing Plants for Dead Animals, was passed by the Diet with responsibility for the enforcement of this law being under the jurisdiction of the Ministry of Welfare. Control measures were instituted to prevent dissemination of animal diseases to neighboring areas in the vicinity of these plants. All records of known cases of disease are being coordinated with the Ministry of Agriculture and Forestry.

Recently a program was started to make spot area tests throughout Japan to arrive at the approximate percentage of Brucellosis. This

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program was inaugurated as a necessity in determining the relationship between Brucellosis and Trichomonas in that, in Japan, the two diseases are closely associated with each other. If a high percentage of reactors are found then a program of either complete eradication by removal for slaughter or an immunization program will follow immediately.

Inspection and Surveillance

Since the start of the veterinary program constant surveillance and inspections of Japanese veterinary officials at national and prefectural levels have been exercised as a means of correcting the deficiencies found to exist.

Improved sanitary programs have been inaugurated in all slaughter houses and ante-mortem and post-mortem inspection procedures are showing constant improvement resulting from demonstrations and distribution of technical bulletins on this subject. Emphasis has been placed on the sanitary handling of all meats in slaughter houses and meat markets. Meat processing establishments are showing constant improvement resulting from the establishment of sanitary measures necessary to that type of manufacture.

Regulations pertaining to the Food Sanitation Act, Law No. 233 of 1947, are being enforced by the Ministry of Welfare. Food inspection conducted at prefectural level is receiving a subsidy from the national level and the inspection service is constantly undergoing expansion. Emphasis is being placed on the inspection of all seafood which constitutes the main source of protein in the Japanese diet. Prefectural Food Inspection Laboratories provided for in the Food Sanitation Act, are being established to determine the quality and safety of foods now being offered into commercial channels. Representatives of the food industries were encouraged to establish a Food Association through the medium of which, literature is being disseminated to all food processors as a means of establishing good sanitary measures necessary in the handling and processing of all food and beverages.

The Dairy Score Card and the Dairy Plant Score Card methods of inspection, currently used by the United States Public Health Service, was introduced into Japan in November 1946 and are being utilized in all the 46 prefectures. The use of these score cards has had a marked effect in establishing better cooperation between dairy farmers, milk plant operators and the prefectural inspectors. The standardization of operating methods in the dairy milk plants has been stressed and the Ministry of Welfare has cooperated in obtaining critical laboratory reagents necessary in the improvement of the required testing of milk samples.

The nation wide health center program calls for one public health veterinarian to be assigned to each health center. The selection of personnel for these assignments is proceeding satisfactorily and is resulting in a more efficient coordination of veterinary activities in each health center district. This has also served to establish a better liaison with the animal disease control programs thereby accentuating the value of this service in the protection of public health.

Veterinary officials in the Ministries of Welfare and Agriculture and Forestry were encouraged to make more prefectural inspection trips for the purpose of establishing a closer alliance with prefectural

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officials. Such action stimulated the activation of many programs which previously have received very little attention.

Society for Prevention of Cruelty to Animals

A Society for Prevention of Cruelty to Animals has been reformed and recognized as a juridical body. This society sponsors the establishment and maintenance of animal dispensaries throughout Japan to alleviate suffering in those animals whose owners are unable to afford treatment. The functions of this Society have been coordinated with the Ministries of Welfare and Agriculture and Forestry and their support therefore assured.

Conclusion

As Japan's livestock was severely depleted during the war, it is planned to emphasize the present program on artificial insemination as a shortage of breeding males prevents full coverage under normal breeding conditions. The location of many breeding animals in remote and frequently inaccessible areas has contributed largely to the slow recovery of livestock to prewar figures.

Future plans provide for a continuation of all programs currently in force. Improving the qualifications of veterinary personnel and educating them in modern veterinary standards and inspection procedures will be emphasized.

Animal disease control will continue to be stressed with more attention given to prompt detection of all animal disease outbreaks. Tuberculosis testing programs will be expanded, likewise the rabies immunization program.

In the field of veterinary education, future plans consist of placing all educational reforms in operation, establishing a modern circulating library and also implementation of the new national licensure examination requirements.

The expansion of the present food inspection service will be emphasized by the addition of increased numbers of inspectors who will undergo periodical training in refresher schools as well as dissemination of pertinent material through the publication of technical booklets on the subject.

An intensive survey of all manufacturing establishments producing animal biologicals is to be made and rigid controls established. Additional plans will be formulated for a mandatory requirement that all biologicals be assayed under the supervision of the National Kodaira Assay Laboratory, an institution under the direct control of the Ministry of Agriculture and Forestry.

Expansion in the present scope of subjects now being taught at the Institute of Public Health and Ministry of Agriculture and Forestry refresher schools will be carried out as a means of modernizing the current schedules.

Plans are being formulated for implementation by the Ministry of

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Agriculture and Forestry for equipping all quarantine stations to permit a complete inspection on all animals and animal by-products offered for export or import.

These overall plans will be supplemented by the publication of technical bulletins covering various phases of veterinary programs to be used as references and guides for Japan veterinary officials.

Chapter 6

WELFARE

Public Assistance

Relief work in Japan prior to the Tokugawa period (Ante 1603 A.D.) was carried on by the voluntary charity of the Emperor, the occasional "mercy" of Buddhist monks, the custom of mutual support by members of the same family (the family system) and the traditional spirit of mutual help among neighbors.

Relief legislation had been sketchy and patchwork in character. In contrast to the Christian concept of the worth and dignity of the individual, the Japanese followed the Confucian doctrine in the five human relationships: (1) subjects to their Prince, (2) children to their parents, (3) wives to their husbands, (4) younger brothers to their elder brothers, and (5) neighbor to neighbor. No responsibility or obligation was extended to the stranger. (Ref. chart 19).

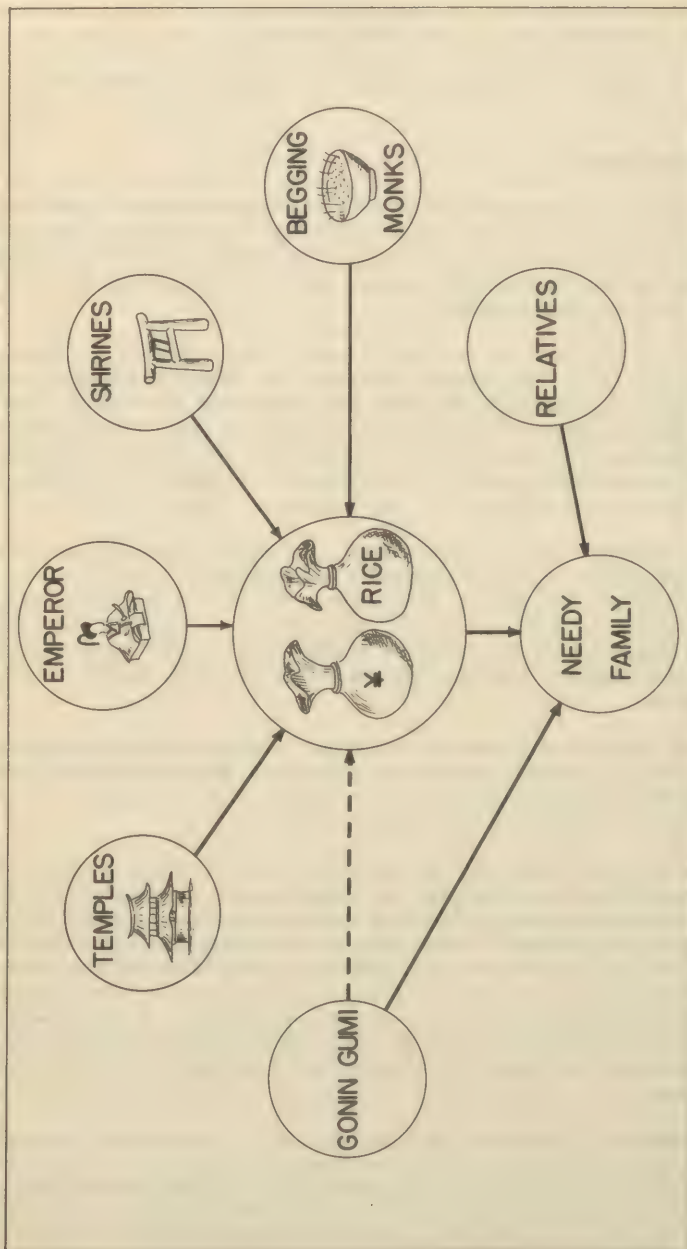
While such a system might work in a simple agricultural society, by the middle of the 19th century a succession of rice riots by a hungry populace brought on the restoration of the Emperors. It may be considered that the indirect cause of the collapse of the shogunate and the emergence of the Imperial family (1863 - 1868) was the failure of the Tokugawas to provide for the needs of those unable to care for themselves.

The industrial booms and resultant depressions following the Sino-Japanese, Russo-Japanese and the First World War forced the government to take measures in providing for the indigent worker during periods of sickness and unemployment.

In 1874 the first relief law was passed. It was a legislative endorsement of the old family and neighborhood responsibility idea and avoided the meeting of relief needs by the government. From 1890 until 1929 attempts were made to introduce and secure an adequate poor relief law in every session of the Diet but each time met the opposition of the industrialists then in power. They maintained that such legislation "would encourage idleness." A relief law, passed in 1929 and effective in 1932, made no impression on the over-all problem as no funds were appropriated to carry out the provisions of the law.

While the government was making only a half-hearted advance in the welfare field, the efforts of Christian missions in appealing for individual rights finally stung the Buddhist elements into joining action at their side. In 1918 there were 92 public and 1,255 private welfare institutions which ranged from insane asylums to rescue homes for prostitutes.

JAPANESE FEUDAL RELIEF PROGRAM



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In the field of industrial protection, the first factory workers law movement started in 1882, but legislation was not passed until 1911, becoming effective in 1916. Rice riots in 1918 forced more beneficent legislation in the labor field.

Laws chiefly concerned with relief at the beginning of the Occupation were the Poor Relief Law, Military Aid Law, Protection of Mothers and Children Law, and the War Sufferers Relief and Medical Protection Law. These were administered by the Ministry of Welfare through local government welfare agencies upon certification mainly by Homen-in (Volunteer District Welfare Commissioners appointed by Prefectural Governors) numbering some 80,000 throughout the nation. Relief was also handled by volunteer or private organizations receiving support largely from government subsidies and gifts from large corporations. (During the war, however, all relief activities were disorganized and limited in their benefits.)

The abrupt end of the war and the result of the final phase of aerial bombings left the Japanese Government and people in a state of shock, wholly unprepared to meet the emergency problems of health, food and shelter. Functional government had broken down and the Japanese people were undecided as to what was expected of them.

Daily Life Security Law

It was realized that immediate action was necessary to secure a reserve supply of food and clothing to be used for relief needs in emergencies. This was accomplished by seizing former Japanese Army and Navy stock-piles of food and requiring the Japanese Government to warehouse these foods and hold them for distribution upon orders of SCAP. This food stock amounted to more than 30,000 tons of biscuits and canned goods.

Japanese Army and Navy clothing stocks were also taken into Allied custody and held for relief as needed. At designated periods these supplies were released to the Japanese people when food and clothing in normal governmental channels became exhausted. In addition to the food supplies attained from former Japanese Army and Navy stock piles, 100,000 tons of wheat were imported from the United States as a relief reserve.

One of the first directives issued by SCAP in the relief field was "Relief for Hiroshima" in which approximately 12 tons of medical supplies were dispatched for the International Red Cross delegate in Hiroshima for use in the relief of Japanese persons injured by the atomic bomb.

On 8 December 1945, SCAP directed the Japanese Government to: (1) submit a plan for meeting the relief needs of the people during January to June 1946, (2) estimate the number in need of relief, and (3) provide necessary legislation. On 31 December the government advised SCAP of their plans for a comprehensive relief law to be administered by a quasi-official agency. A limit of ¥200 was proposed

as the maximum grant per month for families of five. Eight million persons were estimated to be in need of relief. (Later reports revealed the case load to be 2,500,000) This plan, as submitted by the Japanese Government, was unacceptable to SCAP as it delegated to a quasi-official agency administration of the relief program for the nation.

On 27 February 1946, SCAP directed the Japanese Government to establish a single national government agency which, through prefectural and local governmental channels, would provide adequate food, clothing, shelter and medical care equally to all indigent persons without discrimination or preferential treatment. An additional provision was added that "within the amount necessary to prevent hardships, no limitation to be placed on the amount of relief furnished."

The subsequent plan, as submitted by the Japanese Government, was acceptable and resulted in the birth of a modern public assistance program with passage by the Diet of the Daily Life Security Law which became effective 1 October 1946. The law is modern and complete. Thus the Japanese Government became one of the few governments of the world which accepted responsibility for the relief needs of its people.

The Daily Life Security Law:

1. Established government responsibility for providing adequate assistance to needy persons equally without discrimination or preferential treatment.
2. Defined the roll of governmental agencies and public and private institutions.
3. Provided expenses for food, fuel, clothing, housing, medical care, occupation aid and funeral aid to needy persons.
4. Specified financial participation of all governmental levels, with the central government bearing the larger share of the costs.

Since passage of this law, several nation-wide increases in the family budget have occurred. Increases have been based upon increases in the cost of living as well as a desire on the part of the Japanese Government to provide for minimum standard of living for those in need. Sanitary conditions, food and medical care have been immeasurably improved.

One of the weaknesses in the Japanese Government welfare administration has been the lack of field supervision. This is true of all levels of government. The recent inauguration of a limited field supervisory staff of seven field representatives in the Ministry of Welfare is a proper step in the right direction. Several prefectures have also inaugurated similar programs.

During the past few months a standing committee, authorized by the Ministry of Welfare, has been attempting to set up a basic standard of requirements for families and individuals upon which family allowance

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may be based. Delays in release of official rations and delays in release of public assistance allowances make pricing of a standard of requirements extremely difficult and thus limit the effectiveness of the use of such figures for standard family allowances for public assistance.

During 1948 a nation-wide review of public assistance cases was completed. The review was based on the need to determine the eligibility of all public assistance cases as well as to provide a training tool for in-service training of local officials and those volunteer workers (Minsei-in) responsible for much of the work in the public assistance program. The review proved of value in both instances.

Also during 1948 the public assistance program was gradually developed into a complete, well-rounded assistance program providing a means by which eligibility can be correctly determined, with provision for food, housing, fuel, incidentals, medical care, birth aid, funeral aid and occupation aid. The plan provides for deduction of income and resources and the allowance is based on the needs of the individual family. (Ref. chart 20)

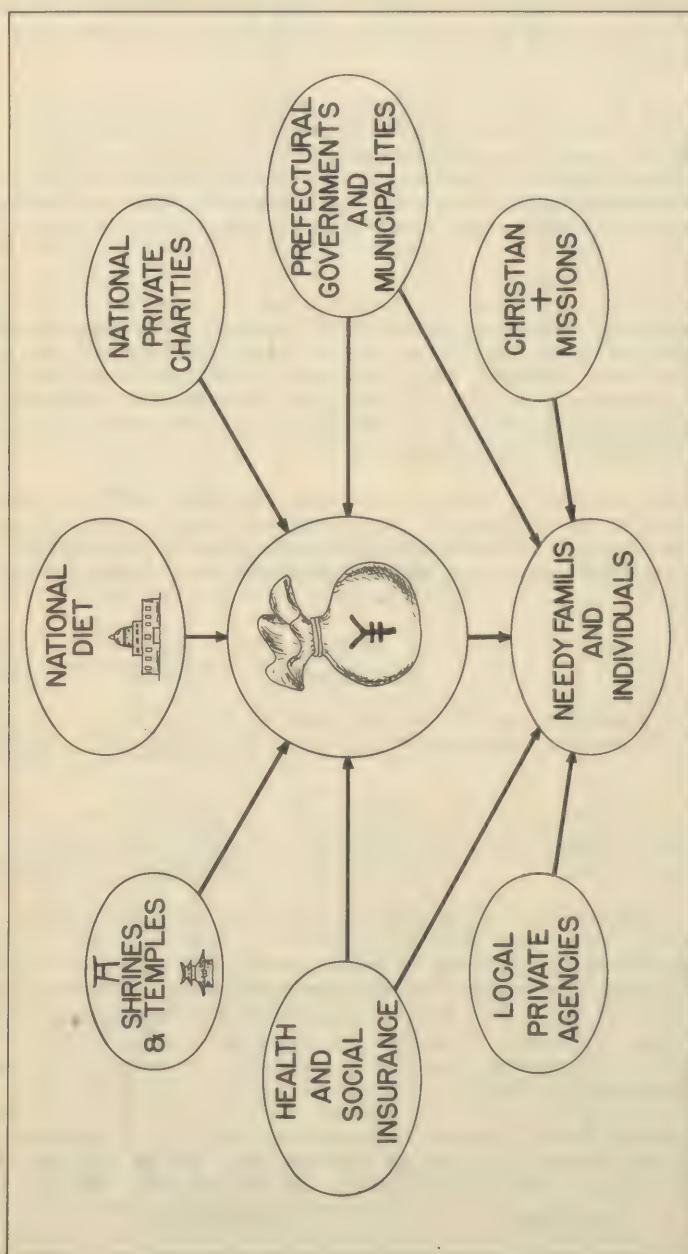
Public assistance totals in persons and costs reflect a decrease in recipients and an increase in expenditures during 1948. Indicated below are figures for December 1948 with figures for December 1947 and December 1946 shown for purpose of comparison. (Ref. charts 21 and 22)

	<u>1948</u> <u>December</u>	<u>1947</u> <u>December</u>	<u>1946</u> <u>December</u>
Persons - Institutional	140,284	138,623	92,778
Persons - Non-institutional	<u>1,703,941</u>	<u>2,702,650</u>	<u>2,744,429</u>
Total	1,844,225	2,841,273	2,837,207
Assistance - Cash	627,365,281	399,638,024	144,075,959
Assistance - Kind	<u>20,226,497</u>	<u>39,704,857</u>	<u>62,045,606</u>
Total	¥ 647,591,778	¥ 439,342,881	¥ 206,121,565

A simple appeals system is being developed and will be implemented early in 1949. The system will provide for an appeal to the next higher authority in the event of dissatisfaction concerning rejected applications and amount of assistance provided. It is believed that such a plan will provide a method by which the operations of local officials may be analyzed.

Continual strengthening of statistical and fiscal procedures will be necessary so that information assembled will be of value in social planning and in granting of funds to local government. Analysis will be made of those persons receiving public assistance and the reasons therefor. Analysis will also be made of the effects on families in which there is no normal breadwinner, with particular emphasis on those families with children.

CURRENT WELFARE PROGRAM



PERSONS RECEIVING PUBLIC ASSISTANCE

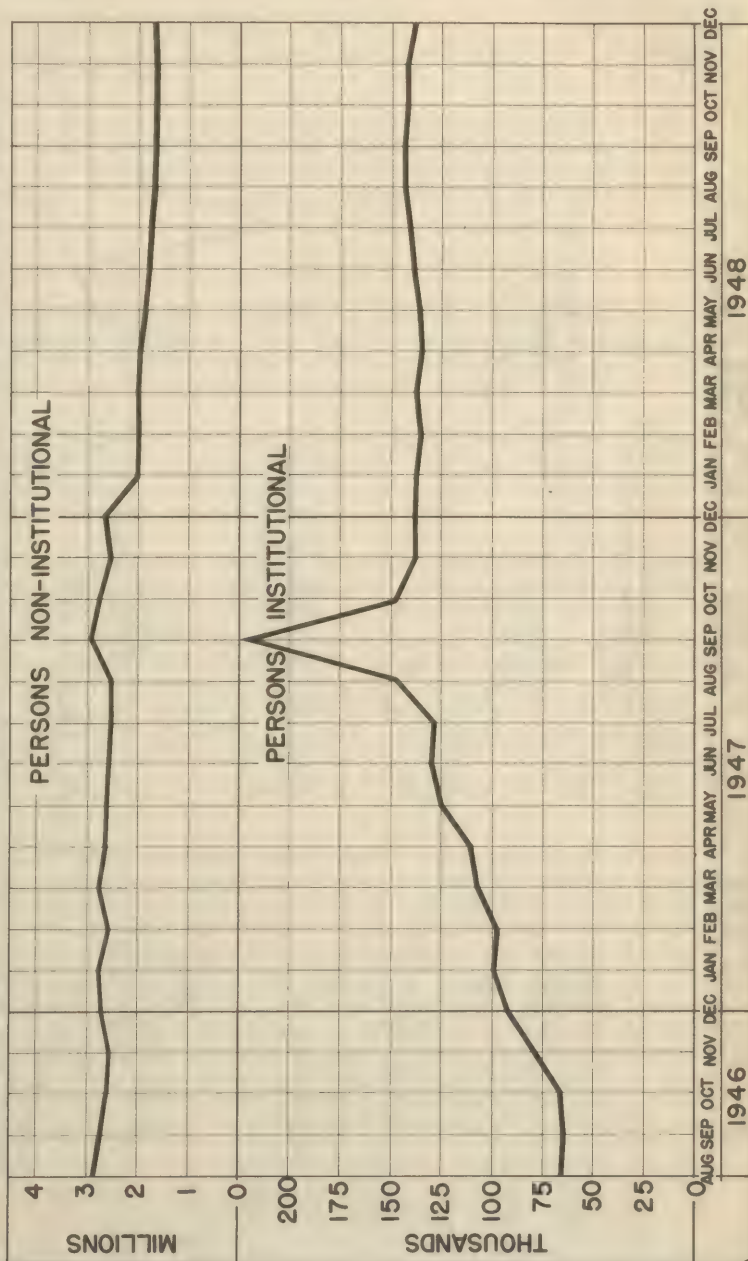


Chart 21

COST OF PUBLIC ASSISTANCE

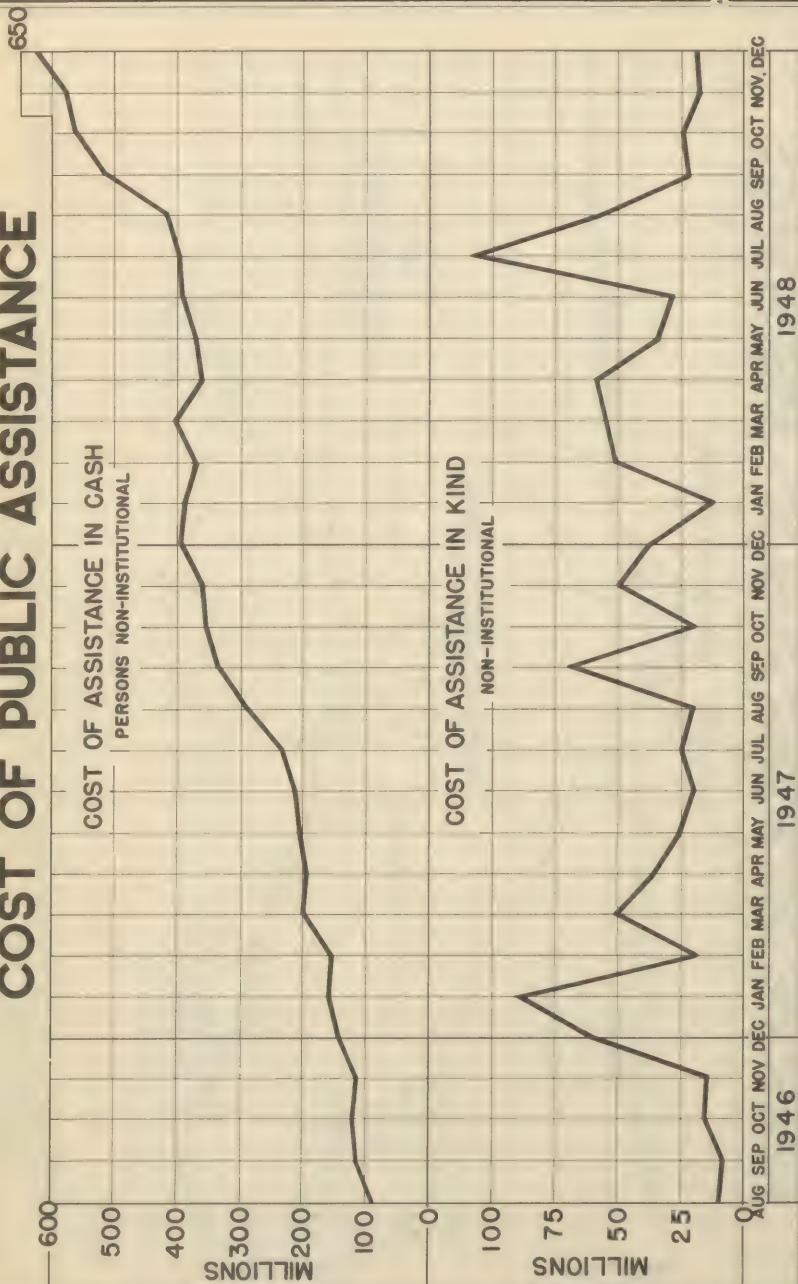


Chart 22

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Complete review of the administrative management of the program will be undertaken with particular emphasis on the administrative organization of the prefecture, district and city, town and village offices as well as the functional line of administrative authority through these offices.

Increasing cost of the medical care program will be analyzed to determine causes, with a review of the eligibility system. A study of the effect on the public assistance medical program of the greatly increasing participation in health insurance programs is also planned.

Repatriation

At the close of the war almost 7,000,000 repatriates were awaiting repatriation to Japan. This would have presented a gigantic absorption problem even in normal times and was made extremely difficult due to the economic collapse following the termination of hostilities.

In addition to the medical processing of repatriates, which is covered under Chapter 2, Preventive Medicine, Port Quarantine, the Japanese Government provided a number of programs designed to meet the welfare needs of these persons.

At the repatriation center, activities included the exchanging of money in a sum not to exceed ¥ 1,000 and the issuance of a Certificate of Repatriation. Free room and meals were provided and a free ticket to the repatriate's destination was furnished including food (biscuits or bread) for the trip, clothing and bedding if needed, plus a gratis issue of ¥ 1,000 per person (¥ 2,000 per family head; ¥ 1,000 for each additional member), if the repatriate was without funds. Repatriates were also given free medical care including hospitalization, if authorized by the repatriation center doctor. Repatriates could bring with them only that which they could carry on their backs and the equivalent of ¥ 1,000.

Enroute from the repatriation center to the place of destination, the national and local governments coordinated in providing places of rest, feeding, and medical treatment in the stations along the route.

To date, approximately 6,135,979 persons from Korea, China, Dutch East Indies, Formosa, United States, Canada, Australia and the islands of the South Pacific have been returned to Japan. There are approximately 469,000 repatriates in Sakhalin, Siberia and Manchuria to be repatriated; the majority being in Russian-held territories. The U.S.S.R. has failed to accept the offer of SCAP to supply ice breakers to keep the Siberian ports open to allow winter repatriation operations, but movement is scheduled to resume in the spring of 1949.

Governmental Assistance

Japanese Governmental programs for "war sufferers and repatriates" include a number of special projects designed to meet the needs of not only those made homeless by the war, but also for the millions of

returning civilians, many of whom had never been in their home country. Repatriates come under the provisions of The Daily Life Security Law and receive the same care and treatment as other Japanese citizens.

When the repatriate reaches his selected place of residence he secures work in his profession or trade either through the local employment bureau or through his family. If nothing is available locally, he is advised of the location of work and assisted in reaching it.

In those cases where the repatriate cannot find employment or is unable to care for himself or his family, he receives care under the provisions of the Daily Life Security Law and in addition receives cooking and household equipment, five days' free rations, ration cards, sufficient relief funds to purchase food and a free but limited issue of clothing. Distribution varies from prefecture to prefecture dependent in part upon local resources. Through the local Social Affairs Offices, housing is provided by the utilization of former factories, barracks and warehouses or similar large unused structures. At the current time however, only 6% of the people repatriated are so housed, the remainder having secured shelter by "doubling up" with relatives and friends.

Business loans not in excess of ¥ 7,000 are available through the people's banks for use in establishing small business enterprises or in the purchase of small tools. These loans draw no interest for one year, 6% for the next four years, and are due and payable at the end of five years. Loans to 410,000 households have exceeded the ¥ 1,926,000,000 loan fund and demands are currently being made for additional funds, a larger loan limit and longer terms.

Repatriates desiring to settle on land may purchase acreage through the Ministry of Agriculture and Forestry. They may borrow up to ¥ 20,000 for this purpose or rent land and borrow from the Ministry for farm tools, equipment, seed and fertilizers. This permits a total of ¥ 27,000 in loans from the Ministry of Agriculture and Forestry and the people's banks that can be available to these repatriates.

Upon returning to his place of residence the repatriate presents his Certificate of Repatriation and returns to full citizenship. Certain residence laws will not permit voting until he has lived in his ward or "ku" for six months, although this law has been suspended from time to time to permit large groups to exercise their franchise. The repatriate who wishes to stand for office, however, may do so the day he returns by filing his candidacy.

Special attention is given to the repatriate by the licensing officials in that they give priority to those desiring to open small businesses.

Efforts are being made to carry forward repatriation resettlement on the land, in business or otherwise. Housing for repatriates, an area of real concern, is receiving the concerted attention of the Economic Stabilization Board and the Ministry of Welfare.

Public Health and Welfare in Japan

Population Control

During the final stage of the war, 93 major cities in Japan were partially destroyed by air raids. Great segments of the population, particularly women and children, were evacuated to rural areas. As soon as hostilities were terminated, many people began a general return to the urban centers. This posed a serious problem as housing was from 40% to 80% destroyed in these various cities, food distribution was limited, communications were meager and faulty and sanitation was in disrepair. To allow general return to the devastated cities of some 7,000,000 or 8,000,000 persons without homes or jobs would threaten famine, disease and unrest to a government struggling to restore some semblance of normality.

Also recalled was Japan's former experience in that rice riots would be an early incident and would lead to widespread rioting and general disorder. Establishing soup kitchens, field sanitation and hospital services would be the usual procedure to meet this situation but it would also be the beginning of a chain of emergency stop-gaps that would be all too difficult to terminate at a later date.

Law Concerning Population Movement

On 8 January 1946 the Japanese Government was directed to submit a plan indicating measures to be taken to restrict or prohibit unnecessary population movements from rural to urban centers (cities of 100,000 or more people).

A subsequent Ministry of Welfare Ordinance provided that before a person could move from a rural area it must be established that he had housing in the urban area and that his services were needed in the city. After this was proven, a "permit to move" was given by the local officials and his ration card transferred to the urban area. Without this permit no rations were made available to the individual.

This Ordinance originally was effective for only a given period of time and it was therefore necessary to extend the provision of the directive from time to time.

In November 1947 the Japanese Diet was presented a bill by the Home Ministry on "Control of Public Movements" and on 22 December 1947 approved the bill, which became Law No. 221. This bill carried all the provisions of the former Ministry of Welfare Ordinance and continued to restrict the movement of Japanese people from rural to urban areas until 31 December 1948.

All restrictions governing control of population movements will be lifted effective 1 January 1949 since conditions in general throughout Japan, including metropolitan areas, have improved sufficiently (housing, food supply, rationing procedures, transportation, etc.) to justify their discontinuance, and a return to normalcy as it relates to the free movement of the people has been accomplished.

As a result of the control of population movement measures that were taken, refugee massing in metropolitan areas was prevented, soup kitchens were avoided, disease, suffering and distress was kept at a minimum and civil order was maintained. These measures also resulted in many former urban dwellers settling in rural areas where they will continue to remain even though they may now return to urban areas.

Foreign Nationals

At the beginning of the occupation, foreign nationals numbered 2,000,000 Koreans, 30,000 Formosans and Chinese and 7,500 various other nationalities.

Monetary relief to foreign nationals was not required, but to prevent malnutrition it was necessary to supplement their diet. The enemy national problem was further aggravated because the funds of the Germans were blocked and their movements restricted to meet security requirements. No jobs were available, neither were there funds to purchase these supplemental rations. About 545 of these foreign families were German women and children from the Dutch East Indies and their plight would have been critical had not some form of relief measures been undertaken.

Relief and Care

Several directives to the Japanese Government required that they provide, regularly, supplementary rations for all resident nationals of the United Nations, neutral nations and stateless persons. The enemy foreign nationals have been made the responsibility of the Japanese Government to provide the essentials to meet the minimum standards of health and welfare. The Japanese Government's plan for relief in kind was approved and as a result no enemy nationals were forced to go without the daily necessities of life.

These basic policies established during the Occupation have been sound and at no time has there been general suffering among the foreign national group. On 9 January 1948 SCAP further implemented this policy as it relates to food by assimilating into the same care and treatment as provided for foreign nationals, the same care and treatment henceforth to be rendered to former occidental enemy nationals.

This action was necessary because certain former enemy nationals had exhausted their reserve stocks of food and from physiological needs were in need of the same rations as other occidentals. This implementation had the effect of restoring to a small group some semblance of normalcy and at the same time obviated discriminatory treatment because of nationality background.

Of those foreign nationals who were residents in Japan at the time of the surrender, approximately 600,000 Koreans out of the original group have elected to remain in Japan and receive the same care and treatment as Japanese citizens. Chinese-Formosans and other foreign national groups have been given opportunities for repatriation; however,

very few persons in these categories have elected to be repatriated.

Housing

Prior to World War II it was estimated that Japan had 14,000,000 homes which included structures of all types of construction, from modern cement and wood buildings to the typical style Japanese wood and straw buildings. At the end of hostilities some 4,500,000 homes were destroyed through bombings, fires and natural catastrophies. As the nation had diverted its efforts to war-time requirements, no new building construction had been undertaken; consequently, a serious housing deficiency existed.

Board of Reconstruction

The Board of Reconstruction was established early in 1946 and was made responsible for the surveying of housing needs and making available essential materials based on these surveys. It authorizes all building permits and since 1 August 1946 such permits for all Japan have been controlled.

Building Progress

Progress has been steady even though natural catastrophies such as the earthquake and flood in Okayama prefecture and Shikoku region areas in 1946, the Kanto region flood in September 1947, and the Fukui earthquake disaster in July 1948, resulted in further housing shortages.

Building from 1945 to date is as follows:

1945	-	157,000 units
1946	-	288,761 units
1947	-	404,846 units
1948	-	667,832 units

As of 31 December 1948, a need for 4,717,000 dwelling units still exists, mainly as a result of the repatriation program. Even with acceleration, it will take five years more to reach a minimum level of adequate housing.

Currently underway in Tokyo is a demonstration housing project consisting of two units, 600 homes each, which are being erected in burned-out areas in Akihaba ward. The buildings were purchased from Army surplus stocks and consist of prefabricated houses, size approximately 12 x 14 feet. Plans provide for making these houses available to war victims, repatriates and returned ex-service personnel. The project is 50% completed and will be ready for occupancy 1 March 1949. Water mains, sewage disposal and a power distribution system is being installed and roads are being graded. Play areas for children and

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public baths for the entire area will be features of the total program. Rents will be reasonable (¥600 - ¥800 per month) and the general standard, from a public health and safety standpoint, is above average and suitable for demonstration purposes.

Licensed Agencies for Relief in Asia (LARA)

Early recognition by SCAP of the need for a single channel through which to funnel all donated relief supplies coming to Japan from the United States and other countries resulted in an agreement with interested organizations and the inauguration of LARA. On 30 August 1946 SCAP directed the Japanese Government to accept, warehouse, account for security, and distribute relief goods shipped to Japan which had been donated by groups, individuals and volunteer agencies in America making up the LARA organization. Under the SCAP - LARA agreement, the Japanese Government assumed all costs from dock to distribution under the general supervision of SCAP. LARA was authorized to ship up to 2,000 tons per month. Their primary plan of operations was to raise the caloric intake of persons in institutions, orphanages, hospitals and sanatoriums by supplementing the food received in the official Japanese rations.

Relief Shipments and Distribution

The first shipment of LARA relief goods arrived in Japan 30 November 1946 consisting of 350 tons of food and clothing. As of 31 December 1948, 116 shipments have been received totaling 7,174.21 tons as follows:

Food	5,459.98
Clothing (including shoes)	1,342.08
Medical Supplies (including medicines)	61.52
Cotton (raw)	207.62
Miscellaneous (soaps, seeds, candles, etc.)	<u>103.01</u>
Total	7,174.21

The distribution of the above relief items approximates the percentages shown in the tabulation below:

<u>Where Distributed</u>	<u>Food</u>	<u>Clothing</u>
<u>Welfare Institutions</u> , including baby clinics and day nurseries	47.4%	46.1%
<u>Sanatoria</u> (Lepor and Tuberculosis)	7.5%	1.0%
<u>School Programs</u> (supplementing school lunch programs)	37.7%	8.9%
<u>Disaster Relief</u>	6.6%	7.4%
<u>Special Projects</u> , such as milk stations	0.3%	3.4%
<u>Repatriates</u> , including other needy persons	<u> </u>	<u>33.2%</u>
	100.0%	100.0%

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In addition to the above relief supplies, the LARA organization has been the agency through which the Heifers for Relief Committee of the Brethren Society (U.S.A.) have shipped, as gifts to Japan, up to 31 December 1948, a total of 1,528 goats, 37 bulls and 35 heifers.

The above livestock is being used to increase the stock herds, thereby increasing milk production, developing stock farms and research agricultural stations and also for a welfare rehabilitation project in which allocation of the animals is being made to various private and public welfare institutions throughout Japan.

LARA maintains three official liaison representatives in Japan with Public Health and Welfare Section, GHQ, SCAP. Supervision of the receipt and storage of each shipment of LARA relief goods is a function of SCAP. The allocation of the relief items is accomplished by a LARA Central Committee whose membership includes representatives from LARA, selected indigenous welfare agencies, Japanese Government and the Occupation Forces. All goods are distributed, after their allocation, through official Japanese Government welfare channels and under the supervision of the Public Health and Welfare Section.

Thousands of letters have been received from recipients of this program thanking SCAP and LARA for the benefits which have resulted and expressing hope that it will continue to function. It is anticipated that the need for LARA relief goods will continue for at least one or two more years.

The Japanese Red Cross

The Japanese Red Cross was regarded as the second greatest Red Cross society in the world. Its organization was not dissimilar to that of the American Red Cross, but in function it followed the European pattern with special emphasis placed on a nation-wide system of hospitals, clinics, sanatoria and schools of nursing. Prior to World War II the society, by Imperial Ordinance, was placed under the control of the Sanitary Commission of both the Army and the Navy. The war-time Red Cross program, therefore, was geared to the war effort and its pre-war activities were measurably altered to meet military demands.

Reorganization

On 20 September 1945 the American Red Cross was invited to assist Public Health and Welfare Section, SCAP, in reorganizing the Japanese Red Cross society along democratic lines with primary emphasis on serving the civilian health and welfare needs of the Japanese people.

Like other indigenous agencies during the first months of the Occupation, the Japanese Red Cross went through the stages of shock and confusion preceding its initial efforts at reactivation and reorganization. Personnel were immediately screened at national and chapter levels and many of the war-time leaders were found objectionable and subsequently dismissed. Under the temporary leadership of

acting officials, national reorganization proceeded slowly. Recruitment of new and competent personnel was difficult and the society was further handicapped because of the lack of sufficient funds for payment of salaries. Personnel recruited were unfamiliar with Red Cross activities and lacked knowledge and confidence in undertaking their responsibility.

The formalization of new statutes approved by SCAP and the Japanese Government in December 1946, and adopted by the society in January 1947, provided for the complete separation of the society from government. The new statutes provided a democratic basis of organization and function by which the society could develop programs and services needed by the people of Japan. Principles of Red Cross organization and function as defined by the International League of Red Cross Societies were also incorporated in the new statutes.

Concurrently with its reorganization the society faced the task of reactivation and continuation of basic Red Cross services programs. Efforts were initially directed to hospital and medical services activities. While many of the hospitals and clinics were totally or partially destroyed during the war, medical and clinical services to the civilian population were continued and in many communities afforded the only medical facilities available. In all, 41 general hospitals were placed in operation together with four maternity hospitals and ten tuberculosis sanatoria. Thirty-four clinics, many of them caring for up to 50 bed patients, were also activated. Approval was obtained for the release of frozen funds with which to finance necessary repair and reconstruction of these facilities, particularly in communities where Red Cross provided the only medical service available.

Expansion of the Red Cross Program

Election of officers under the new statutes took place in January 1947 and it was not until then that the Society's legal reorganization could be considered complete. With the election of its new officers, the Society for the first time began to express sound aggressive leadership. Assistance of American Red Cross consultants resulted in plans being initiated for the reorganization of its principle services, including Junior Red Cross, disaster relief and nursing services.

In Junior Red Cross, a new and inexperienced staff was oriented in the principles of the International Junior Red Cross movement and significant progress was made in activating plans for new and effective activities in schools throughout the nation.

The earthquake and tidal wave disaster of 21 December 1946 in Okayama Prefecture and the Shikoku region of Japan gave the Japanese Red Cross an excellent opportunity to demonstrate its traditional role in time of disaster; namely, providing emergency medical and nursing services to disaster victims. Following this disaster, intensive work was accomplished in developing plans for more extensive responsibilities for disaster relief services.

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The reorganization of nursing services made a significant advance with the appointment of a nurse as Chief of Nursing Education, the first time a nurse has held this position in the Japanese Red Cross Society. Five percent of all nurses in training in Japan are enrolled in the Japanese Red Cross Schools of Nursing; therefore, the significance of this appointment to the nursing profession is readily apparent. Under the guidance of an American Red Cross consultant on nursing services, the society has established home nursing programs throughout the 46 prefectures in Japan, fashioned after the American Red Cross Home Nursing Course.

In addition to the programs enumerated in the preceding paragraphs, attention has been given to the development of such services as water safety and first aid, volunteer services and public relations and information. Because of the lack of specialized consultant service, comprehensive assistance could not be given the society until the fall of 1947.

The New Society

During the first two years of the Occupation the reorganization and expansion of Japanese Red Cross services were completed sufficiently to permit the Society to assume additional responsibility toward the Japanese people.

Modern concepts of publicity and fund raising were introduced to the Red Cross for the first time during a membership and fund raising campaign conducted in October and November 1947. While only ¥142,024,580 or 47.3% was raised toward the national goal of 300 million yen, the campaign was successful in many respects and provided valuable experience upon which to build a more effective fund raising organization for the fall campaign in 1948.

The Community Chest and the Japanese Red Cross experienced some difficulties during the campaign in the fall of 1947 since there was an overlapping of their campaign dates. This conflict also accounted for each of their fund campaigns not being as effective as they might have been if there had been a sufficient spread of time between the two campaigns. It was the decision of the two organizations, since they both wanted their campaign in the fall of 1948 at approximately the same time, to join together for a "Joint Fund Campaign." The national goal was set at ¥ 1,175,450,000, and as of 31 December 1947 a total of ¥ 1,005,968,747 had been raised and there was every indication that the campaign would only fall short of its goal by approximately 8%. (Note: The total amount raised by these organizations in their separate campaigns last year was ¥ 713,096,261).

Under the provisions of the National Disaster Law, enacted in December 1947 and subsequent agreements with the Ministry of Welfare, the Red Cross was given the responsibility for the administration of disaster, medical and nursing services and for the coordination of all non-governmental relief or welfare agencies in time of disaster. The Fukui earthquake disaster in June 1948 gave the Society another

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opportunity to demonstrate its ability in this respect and they discharged their duties in commendable fashion.

The plan for the reorganization of the Junior Red Cross program was approved and introduced to prefectural Red Cross and Japanese educational officials at a series of regional orientation meetings. Implementation of this program is now underway. In April 1948 a Junior Red Cross Handbook was published and distributed to Japanese school authorities.

Training courses for instructors in the first section of the new Red Cross Home Nursing program have now been completed in seven of the nine regional areas in Japan. This program has been favorably received in the first classes consisting of lay people.

Substantial agreement has been reached concerning the development of a Volunteer Services Program and for its implementation from national to community levels. Likewise, agreement has been reached concerning the essential organizational steps necessary for the general implement of Red Cross services in branches and sub-branches, including towns and villages.

The national system of Red Cross hospitals, sanatoria, clinics and dispensaries has been closely integrated with the progressive developments noted in the medical services and treatment fields in Japan through December 1948.

The reorganization of the Japanese Red Cross and its place among the International League of Red Cross Societies is receiving proper recognition. At the request of the International Organization, SCAP approved a representative (observer) from the Public Health and Welfare Section and three Japanese Red Cross officials (technical advisors to the SCAP observer) to attend the International Red Cross Conference at Stockholm, Sweden in August 1948.

All of the current programs will be continued with necessary supervision and assistance furnished to ultimately permit the Japanese Red Cross to take their place among the international family of Red Cross nations.

Child Welfare

Child welfare as defined in a modern welfare program, was practically unknown to the Japanese. During the first year of the occupation little progress was accomplished in providing for homeless persons, orphans and waifs. Constant prodding of the Japanese Government by SCAP began to show results in late 1946. A real effort was then made to gather up wandering children and provide homes for them but the project was necessarily slow and difficult.

Additional child welfare institutions were required and better trained personnel were needed. Food, clothing and medical care were difficult to obtain with the result that the maintenance of children in institutions became a major problem.

The Children's Bureau

This problem led both SCAP and the Japanese Government to the conclusion that it was of sufficient importance to establish a Children's Bureau within the Ministry of Welfare. Subsequently established on 15 March 1947, the Bureau consisted of three sections: Planning Section, Foster Home Section and Maternal and Child Health Section.

Existing laws affecting children did not provide for sufficient child protection. In order to give the Children's Bureau a real foundation on which to operate, it was proposed that a new bill be drawn up to provide the necessary legal framework for a modern child welfare law.

The visit of the late Rt. Rev. Monsignor E. J. Flanagan of Boys Town, Nebraska, in the spring of 1947, stimulated considerable interest in the children's problems and drew public support of the need for a new law.

To round out the children's program completely it was decided that a fourth section was necessary in the Children's Bureau. The Bureau is now organized as follows:

1. Planning Section.
2. Child Protection Section.
3. Child Care Section.
4. Maternal and Child Health Section.

A particular point of interest occurred upon the reorganization of the Children's Bureau when a woman graduate of the New York School of Social Work was appointed chief of the new Child Care Section. She is the first woman to hold such a position in the Ministry of Welfare.

During 1948 the prefecture welfare departments organized and staffed child welfare and maternal and child health sections within their framework. These sections became responsible for carrying out the provisions of the Child Welfare Law under the guidance and supervision of the Children's Bureau, Ministry of Welfare.

The Child Welfare Law

The Child Welfare Law became effective 1 January 1948. Following is a brief summary of its provisions:

1. The law points out that the national and local public bodies as well as parents and guardians are responsible for the healthy growth of children.

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2. Establishes national and prefectural Child Welfare Boards to study the needs of children and advise welfare officials of these needs.
3. Provides for the employment of child welfare workers for the promotion of the welfare of children and the welfare of expectant and nursing mothers.
4. Provides for the establishing of prefectural child welfare stations, or centers, for the purpose of child study for proper placement, consultative service, health examinations and guidance, and for other problems.
5. Provides for a maternal and child health program with free service for those unable to pay. Urges expectant and nursing mothers to take advantage of such service. Provides additional food and other necessary supplies for expectant and nursing mothers. Provides obstetrical service in "lying-in" agencies.
6. Provides care and protection for neglected or abused children.
7. Provides for a foster home program.
8. Protects children from exploitation and prevents certain occupations harmful to children.
9. Offers matching funds to prefectural and local governments for provision of and operation of children's institutions.
10. Provides for licensing, minimum standards and periodic inspections of children's institutions.
11. Provides for appeals on local decisions.
12. Provides for protecting individual rights by punishing those who reveal confidential information.

The Child Welfare Law also authorized the employment of full-time paid child welfare workers in the various prefectures in Japan. These officials have now been placed throughout the prefectures and have assumed their duties. This marks the first time in Japan's history that full-time paid governmental welfare workers have been so employed. They operate in conjunction with the Child Consultation Centers and with the many thousands of volunteer child welfare workers (Jido-in), acting as consultants in children's problems and in the problems of pregnant and nursing mothers.

During 1948 all of the provisions of the Child Welfare Law were implemented. Complete Ministerial Ordinances were issued covering the following provisions:

1. Licensing procedure and minimum standards for all children's institutions.

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2. Operation of child welfare centers (child consultation clinics).
3. The foster-home program, including day-care homes.
4. Central and local Child Welfare Committees to study the needs of children and observe the operation of the program.

It is anticipated that 1949 will see further progress in the children's program as more funds are provided by the Diet. Progress, to date, however, has been enormous. The program has caught the imagination of the Japanese who see in its complete implementation the answer to many vexing post-war problems concerning children.

Future Child Welfare Plans

It is planned to establish more positive measures for control of delinquency through effective use of the Child Welfare Centers, also further development of the foster-home program and its controls to effectively abolish so-called "child selling" and "child slavery" as practised in certain rice-poor and rice-rich areas in Japan.

Development of educational material on child welfare through qualified Japanese sources, and the implementation of an informational program for guidance of those working in child welfare as well as for the general public will be emphasized.

Review of operations of "Homes for Juvenile Training and Education" (Kyogo-in) which are now to be responsible for care and training of pre-delinquents, delinquents and those children committing all types of crimes (under 14 years of age) is also planned.

The School Lunch Program

School feeding programs were in vogue in Japan as early as 1880 but it was not until 1929 that the school lunch program, instigated by private social work agencies in the larger cities, began to assume some importance.

In 1929, 204 schools carried out a supplementary school lunch program with an average of 21,600 children being daily provided with a school lunch. Total expenditures during 1929 amounted to ¥ 30,000.

In 1935 it was determined that an increasing number of children were doing without their mid-day lunch due to the economic depression. To meet the dietary deficiencies of children of the low income groups, the Ministry of Education provided a subsidy of ¥ 800,000 to assist the local school authorities in providing mid-day meals for needy school children. This was the first positive indication on the part of the national government of its interest in a school feeding project.

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In 1940, after some preliminary study, it was decided, in conjunction with the educational system, to provide a supplementary mid-day meal for children found to be suffering from malnutrition. Physical examinations revealed that children suffering from malnutrition were found in well-to-do families as often as in needy families. While the children of a family of adequate income received a sufficient quantity of food, due to polished rice being the main component of the diet, the child very frequently showed indications of malnutrition due to the lack of other needed nutrients, protein and vitamins.

From the time of the China Incident in 1937 until the termination of World War II, less and less was being accomplished for the children in need of additional nutrients and by the termination of hostilities the school lunch program had ceased to exist.

At the beginning of the Occupation the food picture in Japan was so grim that procurement of food for a school lunch program appeared to be impossible, although it was recognized that there was a great need for it. Nutritional surveys made in the spring of 1946, and continued every three months thereafter, indicated the greatest need among school children existed in the large urban areas, particularly Tokyo, Yokohama, Osaka, Kobe, Kure, Kyoto and Fukuoka.

A member of the Hoover Food Commission who visited Japan in the spring of 1946 indicated interest in the redevelopment of the School Lunch program and gave valuable suggestions as to how the program might be reinstated. In June 1946 interested SCAP officials further discussed the redevelopment of this program.

Sources of Supply

Difficulties relative to food and fuel procurement and the acquiring of cooking utensils were great, but by December 1946 they were largely overcome and permitted the program to be inaugurated during this month in which approximately one quarter of a million children in the Tokyo - Yokohama area were initially included. Food supplies were obtained through release of former Japanese Army - Navy supplies, from indigenous Japanese sources and some imports. LARA (Licensed Agencies for Relief in Asia) also contributed to this program, supplying a good share of the powdered milk requirements.

In addition to foodstuffs, which have been increased as fast as supplies can be obtained, an allocation of 10,000 tons of coal, lignite and wood was made available for the quarterly period of April, May and June 1948, to meet the general deficit in fuel as reported by individual schools and prefectures. To afford a supply of building materials for the construction of kitchen ranges and cooking facilities, also for limited area flooring, an allocation of 63,000 sacks of cement was made to permit a minimum acceptable standard of sanitation.

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Administration

The program is administered by the Ministry of Education in co-operation with the Ministry of Welfare. Nutritional consultant service is supplied by SCAP, but in general the Japanese Government has now accepted full responsibility for operational control. Participation of children of needy families has been made possible through adjustments in grants under the provisions of the Daily Life Security Law.

Originally providing from two to five mid-day lunches per week to some 251,000 school children, the program has continuously been expanded until now 6.5 million school children are receiving benefits. The average cost has been ¥ 3 per child per day.

While the school lunch program has grown as fast as food supplies have permitted, there has been a simultaneous development of voluntary programs particularly in the rural areas. It is estimated that 600,000 children are being given mid-day school lunches without the assistance of the national government.

All cities of Japan, 200 in number, are now included in the school lunch program in addition to many rural and mountain towns and villages where, by nutritional surveys, it was determined that a deficiency in protein and other nutrients was evidenced. The following figures indicate the expansion of the school lunch program by month:

Official Program by Ministry of Education

<u>Month and Year</u>	<u>Number of Children</u>	<u>Number of Schools</u>
Dec. 1946	251,629	
Jan. 1947	2,052,882	2,168
Feb. 1947	2,835,943	3,221
Mar. 1947	2,906,921	3,619
Apr. 1947	2,974,268	3,312
May 1947	2,974,268	3,450
Jun. 1947	3,057,872	3,689
Jul. 1947	2,942,877	3,830
Aug. 1947	262,970	(summer school)
Sep. 1947	2,986,877	3,990
Oct. 1947	2,908,396	4,391
Nov. 1947	4,092,879	4,840
Dec. 1947	4,137,975	5,467
Jan. 1948	4,773,277	6,693
Feb. 1948	4,880,302	6,818
Mar. 1948	4,834,589	6,961
Apr. 1948	5,209,554	6,958
May 1948	5,261,192	6,958
Jun. 1948	5,385,700	7,490
Jul. 1948	5,517,983	7,826
Aug. 1948	120,011	(summer school)

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<u>Month and Year</u>	<u>Number of Children</u>	<u>Number of Schools</u>
Sep. 1948	6,141,040	8,606
Oct. 1948	6,141,040	8,606
Nov. 1948	6,141,040	8,606
Dec. 1948	6,658,376	9,777

Evaluation of the Program

A study made in 11 prefectures of 33 urban and rural schools indicates a definite weight increase among children included in the School Lunch Program. (Ref. charts 23 and 24). Types of menus provided vary, dependent in part on the local availability of fish and fresh vegetables, but the general average has been 190 - 250 calories per day and the servings have averaged three to five times per week. The United States Department of Agriculture states that one pound of imported powdered skim milk from the United States, in nine pints of water, will afford 18 servings of milk, each serving totalling 180 cc. This milk may be served as a drink or it may be included in soup, the nutritional value being the same in either case. In many areas it has been found desirable to include the milk in a soup as it provides the central hot dish around which to build the other components of the lunch.

It is the object of SCAP to have the School Lunch Program increased to five meals per week for every school day of the year and to raise the caloric content to 600 calories per individual school lunch. The ultimate goal to expand the program to include the 16,000,000 children of compulsory school age (first through ninth grade) has had to be temporarily abandoned because of the lack of appropriated funds to secure essential food imports. At present there is little hope of continuing to include the present 6,500,000 children unless some solution can be found to supply at least the required minimum amount of powdered skim milk.

Disaster Relief

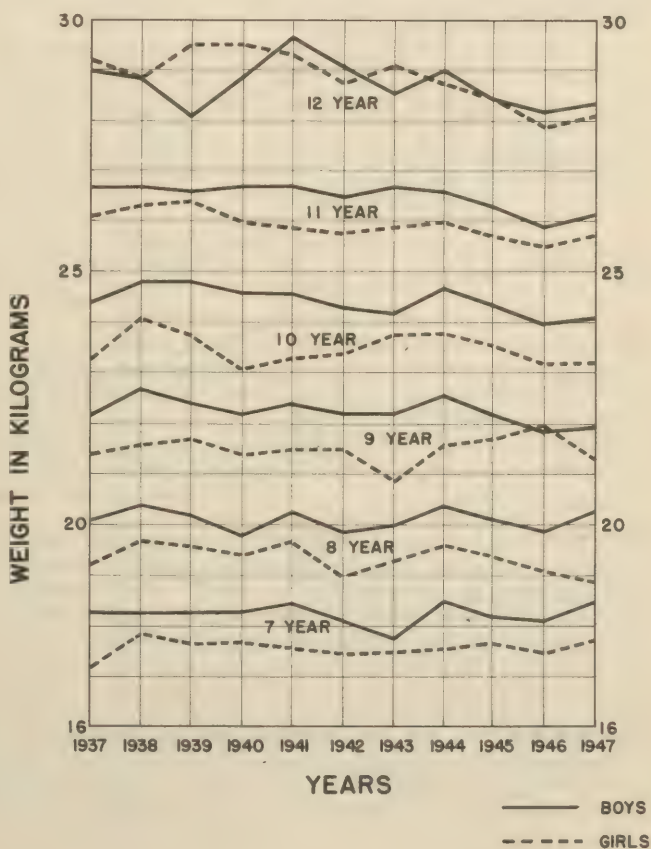
In exploring Japanese plans for the protection of the civilian population against frequently occurring fires, floods, earthquakes and other natural disasters, it was discovered that few prefectures had provided for such emergencies. The laws that were in existence were weak and lacked provisions for finance, direction and coordination.

The total expenditure by the Japanese Government for disaster operations during 1930 to 1933 inclusive (latest available figures) amounted to ¥ 3,844,443.

Early in the Occupation, Military Government Teams had been directed to set up plans for the protection of army personnel and their dependents in the event of disaster. Military Government welfare

AVERAGE WEIGHT OF PRIMARY
SCHOOL CHILDREN IN THIRTY-THREE
RURAL SCHOOLS IN JAPAN:

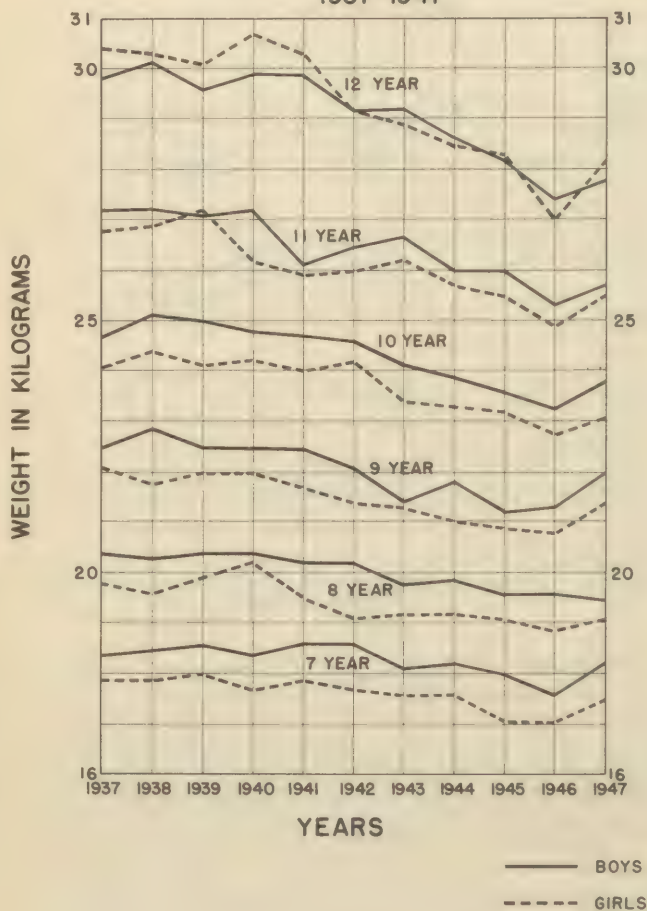
1937-1947



(23)

AVERAGE WEIGHT OF PRIMARY
SCHOOL CHILDREN IN THIRTY-THREE
URBAN SCHOOLS IN JAPAN:

1937-1947



(24)

Chart 24

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officers were in the process of strengthening prefectural planning when, on 21 December 1946, a large scale earthquake and tidal wave occurred which affected 14 prefectures. Difficulties experienced during this disaster focused attention on the fact that coordination at government level was lacking.

The National Disaster Law

As a result of the December 1946 earthquake, a proposed national disaster plan was drawn up. After several months of study, to determine the best means of implementing this plan, it was finally submitted to the Diet and became Public Law No. 118 on 18 October 1947.

The National Disaster Law is based on the acceptance of responsibility by the government in the event of a major disaster. It provides for monetary responsibility by both national and prefectural governments. The law provides for a National Disaster Board headed by the Prime Minister and including all Cabinet Ministers. Also included on the Board are the President of the Japanese Red Cross and competent citizens from the various prefectures in Japan.

The Board is responsible for formulating plans of operations and direction in the event of disaster; also to expedite the flow of disaster supplies.

The Law further provides for Prefectural Disaster Boards which have now prepared prefectural disaster plans. Each prefecture is required to have disaster operating teams composed of police, health officials, welfare officials, economic officials, firemen and engineers. The Japanese Red Cross is recognized as a quasi-governmental agency in times of disaster and is responsible for the coordination of all voluntary groups or agencies.

The Law has proven its workability in several major disasters that have occurred to date, and the people of Japan have benefited by this modern Disaster Law. Japan is the only nation having a disaster relief program wherein a government accepts full responsibility for the total relief of its people in time of a major disaster. During the Ishikawa - Fukui earthquake disaster (June 1948) the implementation of national and prefectural disaster plans was prompt and efficient and was the cause of favorable comment from many sources. Disaster teams from the surrounding prefectures rushed aid to the stricken area immediately following notification of the earthquake and with the Japanese Red Cross coordinating the volunteer agencies, problems of food, clothing, medical supplies and medical treatment were handled efficiently.

Since the passage of the National Disaster Law the Japanese Government has expended a total of ¥ 432,522,633 (national government, ¥ 340,162,081, prefectural government ¥ 92,360,552) in meeting its obligations to those people who were in need of emergency assistance in the following eight major disasters:

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<u>Prefecture</u>	<u>Date</u>	<u>Type</u>	<u>Prefectural Expenditures</u>	<u>National Governmental Expenditures</u>
Iwate	29 Dec 47	Fire	¥ 847,350	¥ 1,355,949
Kochi	4 Mar 48	Fire	511,044	869,795
Fukui	28 Jun 48	Earthquake	32,274,946	189,628,000
Ishikawa	28 Jun 48	Earthquake	3,740,374	7,213,858
Saga	11 Sep 48	Flood	7,245,378	5,428,739
Nagasaki	11 Sep 48	Flood	7,165,809	3,818,532
Miyagi	16 Sep 48	Typhoon	20,135,659	40,880,707
Iwate	16 Sep 48	Typhoon	<u>20,439,992</u>	<u>90,966,501</u>
		Total	¥ 92,360,552	¥ 340,162,081

In this nation where natural disasters are frequent and serious the National Disaster Law will be implemented many times to aid the needy and unfortunate.

Cooperative Agencies for Remittances to Europe, Inc. (CARE)

The CARE Program has been operating in Europe since 1946. Some 17 European countries have received benefits from this program by being the recipients of several million food and clothing packages that had been distributed to individuals in need of relief. CARE is a non-profit organization through which individuals, agencies, societies and similar groups make remittances to CARE, Inc., New York City, in the amount of \$10.00 for each package unit they are desirous of having delivered to an individual or welfare organization. There are several types of CARE package units, namely food, clothing, woolen goods, cotton goods, blankets, medical and infant care.

On 21 August 1947 SCAP authorized CARE to extend their operations into Japan. The first shipment arrived on 10 July 1948 and totalled 9,982 food packages. The food packages for Japan are a special "oriental pack" consisting of 23 pounds (net) of food suitable to oriental tastes. Each food package contains approximately 32,000 calories.

Since the arrival of the first shipment of food packages (oriental pack) other types of CARE packages are now available and have been forwarded for delivery. These additional packages are designated as: "Blanket," and "Woolen." The total number of CARE packages received for delivery has been 23,127 (food, 19,979, woolen, 2,004, blanket, 1,144).

"CARE Sales Stores" have been authorized in Japan for the convenience of Allied Personnel and to also facilitate orders via mail. CARE Operations in Japan have been given APO privileges (CARE, Inc., AF 503, c/o Postmaster, San Francisco, California).

CARE packages enter Japan tax and duty free and the recipients are not subject to any reduction in their regular authorized official food rations.

One of the important features of the CARE program is that each donor must designate a specified recipient with the donor later

receiving a form signed by the recipient showing that delivery was made. Necessary operating expenses of the CARE program are covered by the cost of the package. Delivery of the packages in Japan is being made through Japanese Government postal channels.

Social Work Education and Training

The lack of qualified social workers in the Ministry of Welfare as well as in prefectures, cities, towns and villages was a limiting factor in the development of a sound public and private welfare program. In order to improve this situation, the Ministry of Welfare was advised to establish more adequate in-service training programs for persons already employed. A second approach was the establishment of formal educational programs in colleges, universities and separate schools for persons intending to enter social service work.

Continued emphasis was given to the importance of improving the social welfare program through:

1. In-service training of welfare officials, minsei-iin (volunteer welfare commissioners) and workers in other social agencies.
2. Education for social work in specialized schools.
3. Development of social work courses in universities and colleges for the recruitment and educating of young people for this profession.

The need to give social work status as a profession, in order to attract desirable and qualified personnel and especially more women, led to placing stress on a publicity and educational program. A press conference on social work education and training corroborated the need for dissemination of more information about this field. Through a co-ordinated program with Civil Information and Education Section and the newly organized Information Unit of the Ministry of Welfare, means of meeting this need were begun.

Specialized Schools of Social Work

The Japan School of Social Work, in Tokyo, was established in November 1946 under the joint sponsorship of the Ministry of Welfare and the Japan Social Work Association. A one-year course of study is offered for more advanced students while a three-year course is available for younger students. Assistance has been given the school in establishing an adequate curriculum including provisions for field work training. Students from two one-year courses have now been graduated with the third one-year course currently in process. The second freshman class of students to the three-year course was enrolled in April 1948. Surveys have revealed that 95% of these students who have graduated from the one-year courses have secured employment in public or private welfare agencies.

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Attempts to expand the school's program were retarded by the lack of adequate housing and library facilities. This situation has been remedied by acquiring the former Naval Museum Building in Tokyo. The name of the building was changed to the Central Social Affairs Hall and besides housing the Japan School of Social Work, it houses the national office of the Welfare Commissioners' Federation, the national committee of the Community Chest and the Japan Social Work Association, including their library and the Social Work Institute. Through Civil Information and Education Section the school library received an excellent collection of new American books on social work.

Based on recommendations that a branch of the Japan School of Social Work in Tokyo be established in Osaka, in order that more students from that area may secure at least one year of study of social work, plans were developed which resulted in the Osaka Social Work College officially being opened in October 1948. A total of 93 students enrolled, of which 37 were in the one-year "graduate" course and 56 were in the three-month course, the latter returning to their positions in social agencies (from which they had educational leave) upon their graduation in December 1948.

Both of these specialized schools of social work applied to the Ministry of Education for status under the new educational system as "one subject" four-year universities.

In-Service Training Programs

An in-service training program consisting of eight one-week institutes was established early in 1947. Approximately 50 persons, representing each surrounding prefecture, attended these institutes which were held in eight of the nine regional areas in Japan.

This program was financed by the Ministry of Welfare and conducted under the joint sponsorship of the Ministry, the Japan Social Work Association, and the Japan School of Social Work. This program definitely aided the administration of social welfare projects.

The Ministry of Welfare, in cooperation with the Japan Social Work Association, continued to conduct short institutes all over Japan for welfare officials and others employed in social work. Instructors were officials of the above two organizations in Tokyo and individuals available locally. Subjects covered were: Outline of Social Work, Welfare Committee Work (Minsei-iin), Livelihood Protection, Disaster Relief, Child Welfare Work, Methods of Social Work and Social Survey Statistics. The Minsei-iin Federation has also held national and prefectural conferences and meetings especially for women members. The employment of an in-service training director for Miyagi Prefecture was made possible through a Community Chest appropriation.

Social Work Education

During July and August 1947 a series of meetings were held in Tokyo to consider the matter of social work education in Japan. These meetings were attended by representatives of various social welfare agencies and colleges and universities interested in this subject. A report containing recommendations and standards was prepared and submitted to the Ministries of Education and Welfare as well as other interested organizations and individuals.

As a result of this activity the Tokyo Social Work Education Committee was established to continue study and analysis of these problems.

During the first three days of October 1947, a National Social Work Assembly was held in Tokyo under the sponsorship of various national social work agencies. Delegates from all parts of Japan attended as well as officials of the national government. This assembly was held in recognition of the first year of operation of the Daily Life Security Law and the inauguration of the Community Chest.

The National Social Work Assembly met again in October 1948 in Tokyo with about 500 delegates in attendance. Subjects discussed were: Basic Social Work Laws, Development of Child Welfare Work and Promoting the Social Security System. Dr. Iwao Ayuzawa reported on the International Conference of Social Work which he attended at Atlantic City in May 1948. The Japan Social Work Research Institute presented a program of papers covering administration, community organization, case work, education and several special social problems.

Confronted by the necessity of improving personnel standards in public and private welfare agencies in the Osaka, Kyoto and Kobe areas in Japan, a meeting called by the Governor of Osaka Prefecture in September 1947 resulted in the establishment of the Kansai Social Work Education Committee. This committee consisted of representatives of social welfare agencies and educational institutes in the Kansai area of Japan. Thirteen colleges and universities in this area have completed plans to expand their course of study in the social sciences in order to give a more adequate academic basis for students planning to enter the social service field upon graduation.

The Kansai Social Work Education League (formerly committee) continued to meet monthly, rotating between Kyoto, Osaka and Kobe. Representatives gave reports on social work courses in the universities and colleges of the area. Special talks on social work subjects were presented by invited Americans.

At meetings of social work education groups, Miss Dorothea Sullivan, visiting expert with Civil Information and Education and professor of Group Work at the School of Social Work of Catholic University, Washington, D. C., spoke on group work which led to requesting her services for a two-week course on group work at each of the Schools of Social Work.

The Future Social Work Education and Training Program

Emphasis will be placed on the establishment of social work education programs in colleges and universities in order to provide more adequate academic training for persons intending to enter the social work field.

The need for teachers, experienced both in the practice of social work and in teaching, is acute. The development of a better social work curriculum both in the undergraduate course in colleges and universities and in the two specialized schools, is influenced by this need. Therefore, in the future emphasis will be placed on using every possible resource for obtaining teachers, both for specialized social work training and in-service training and for improving the social work content in all aspects of social work education and training. Further integration of the various in-service training programs from the national to the local level and encouragement of special institutes and short courses in much needed fields, such as medical social work, as demonstration courses, will be stressed.

Present programs will also be continued and expanded with necessary supervision and guidance from SCAP's social work personnel.

Rehabilitation Programs

Physically Handicapped

On 10 February 1948 the Japanese Government submitted a plan for the care of approximately 500,000 persons in Japan who were physically handicapped by reason of injury, serious illness, loss of sight and other causes, including war, bombings, natural disaster and industrial accidents. Among this number, some 324,622 were estimated to be ex-service personnel.

The program was accepted by SCAP on 18 February, provided that it operated on the basis that aid given would be non-preferential and non-discriminatory. This program, designed to rehabilitate the physically handicapped "by instilling a will to work and overcome their problems," was inaugurated in Tokyo on 6 June 1948 with the opening of the first institution for such handicapped persons. Most of the cases were amputees; therefore, provisions for hospital services were made at a nearby national hospital. Such trades are being taught as shoe repairing, tailoring, wood craftsmanship, etc.

The program has progressed now to include 12 Physical Rehabilitation Centers (located in nine prefectures) with adequate facilities to accommodate 1,200 clients.

Another progressive step has been the establishment of a Rehabilitation Section in the Social Affairs Bureau of the Ministry of Welfare to direct and coordinate all public rehabilitation services of the

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Japanese Government for the physically handicapped.

There has also been established the National Council for the Rehabilitation of the Physically Handicapped. This Council is composed of prominent persons in the medical, social and business fields, the heads of progressive public and private physically handicapped institutions and the Ministries of Welfare, Education, Labor and Transportation.

The visit to Japan in late summer of 1948 by Miss Helen Keller, President of the John Milton Society for the Blind, and world-renowned author and lecturer, did much to stimulate public interest and support of the problems the Japanese Government faces in its physical rehabilitation program.

Future plans envision legislation directed for the physically handicapped. A Physical Rehabilitation Law, which will cover every type of physical handicap, is now being drafted by the Ministry of Welfare for presentation to the Diet. This law will permit the functioning of a comprehensive physical rehabilitation program fully utilizing all existing facilities in close cooperation with other interested agencies.

A Model Physical Rehabilitation Center is also contemplated in the Tokyo area to explore and develop practice standards for improvement and expansion of Physical Rehabilitation Centers.

Women War Plant Workers

At the termination of the war many thousands of young Japanese girls lost their jobs in war plants. The majority of these girls who were factory workers up to the end of the war were on the streets without wholesome occupation. Many who had training in specialized occupations were unable to enter their normal fields of employment, as they no longer existed and a great number of these young women were now without homes or family ties. This situation created many unfavorable conditions including health and social problems, as these young women furnished the reservoir from which prostitutes were being drawn.

At the direction of SCAP the Japanese Government, working closely with a Coordinating Committee for Young Women's Welfare, worked out plans for action in the fields of rescue, medical treatment, rehabilitation, etc., for unemployed young women. The Japanese Ministry of Welfare established 12 institutions, centrally located throughout Japan, to carry out the program. This program will be continued under close supervision and will include necessary vocational training and job placement. It is anticipated that there will be a diminishing need for this program in the future.

Consumer Cooperatives

The Cooperative Movement started in Japan in 1900. The farmers and fishermen were among the first groups to organize cooperatives and

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these were followed by the development of cooperatives by small industries and tradesmen. At the close of the war cooperatives flourished in every field of endeavor, but they operated under strict control of the Japanese Government and were often operated by ultra-nationalistic groups.

At the termination of World War II many cooperatives disbanded or were dissolved and were reorganized along world-wide accepted cooperative standards. One group of the Japanese people appeared to have been left out of the cooperative movement. This group was the marginal and sub-marginal economic group composed of day laborers, pensioners and lower salaried commercial and government clerks.

The Consumer's Livelihood Cooperative Association Law, presented to the Diet for consideration, was passed and became effective 1 October 1948. To date 60 new consumer cooperatives have been organized in 28 prefectures under this new law. The new law provides for the absorption by the Consumer's Livelihood Cooperatives, over a two-year period, of approximately 700 industrial cooperatives. To date the program has been operating satisfactorily, but close surveillance will be continued to insure its success.

Community Chest

The constitutional prohibition against governmental subsidization of private welfare agencies and operations, together with the break-up of the "Zaibatsu" caused the loss of these sources of private donations to private welfare activities and forced the private agencies to appeal for help and counsel in planning programs for private agency fund raising. A national committee, similar in purpose to the Community Chest in America, was organized to develop broad plans and programs of fund raising at prefectural level.

First Fund Raising Campaign

The organization of a National Fund Raising Committee for the financing of recognized private welfare agencies was established during the summer of 1947. Fund drives which occurred in the winter of 1947 were preceded by a nation-wide appeal through the press, radio and other media in which an effort was made to secure the participation of every adult in Japan.

This national campaign was held between the dates of 25 November and 25 December 1947.

This was the first such campaign ever attempted in Japan. The national goal was set at ¥ 678,200,000 with each participating prefecture having a quota to attain. Due to the serious Kanto regional flood in September 1947, four prefectures which suffered heavy damages did not participate. The remaining 42 prefectures, however, raised a total of ¥ 571,071,681 or 84.2% of the national goal. This was a very commendable effort for the first such campaign ever conducted in the nation.

Second Fund Raising Campaign

The second national campaign (15 October - 15 November 1948) was designated as "Community Chest - Red Cross Joint Fund Campaign" for the reason that certain conditions made it advisable for these two organizations to join together for fund raising purposes. (Ref. Japanese Red Cross Society, Chapter 6).

The second national call for funds to finance recognized private welfare enterprise was an ambitious one in that the combined goal (Community Chest and Red Cross) was ¥ 1,175,450,000, or an amount exceeding the total amount raised in 1947 by both these organizations, by ¥ 462,000,000. The total collections will not be completely reported by all of the 46 prefectures until on or about 15 February 1949; however, as of 31 December 1948 a total of ¥ 1,005,968,747 had been raised, or 85.5% of the quota. (Note: This incomplete report is an increase of approximately ¥ 293,000,000 over the receipts of both organizations' campaigns for funds in 1947).

It is anticipated that the campaign in 1949 will again be a "Joint - Fund" campaign (Community Chest - Red Cross); however, it is the projected plan to hold the fund raising campaigns of these two organizations separately when conditions in general warrant this independent action.

Chapter 7

SOCIAL SECURITY

Pre-War Summary

Since 1871 the Japanese had developed programs furnishing some form of social insurance protection to most of the population. In 1945 there were more than 10,900 local insurance associations in addition to the national organizations and agencies administering the five major social insurance programs. Approximately 68,000,000 individuals had some form of protection.

The legal framework of Japan's social insurance for other than public employees was of relatively recent date. The first was health insurance for industrial workers and miners. Although introduced in 1922, it was not put into operation until 1927 and in its initial form was very limited in scope and social value. Even more restricted in coverage and in the level of benefits was the Employers' Liability Insurance against employees' industrial accidents, established in 1931.

No provision for unemployment insurance existed for any group. Except for government employees, there was no true workmen's accident compensation insurance. The Employers' Liability Insurance primarily imposed liability upon employers within certain limitations and provided for a fund from which employers could be reimbursed after they had provided medical care or paid out small lump sum benefits.

Modern Japan in the field of social insurance, as in many other fields, took over western institutions without accepting their basic philosophies. The paternalistic and authoritarian character of the Japanese regime had definitely influenced its social insurance program. Although laws provided for unpaid prefectural committees to hear appeals under the social insurance programs, there were no records of any appeals having been made, few people knew that such committees existed and, in many cases, committees had not even convened for the purpose of organizing.

The Five Major Programs

Health (Sickness) Insurance (1922)

This was a compulsory system for employees of industrial, mining, commercial and transportation concerns employing five or more and with contributions divided equally between employer and employee. This insurance provided for both occupational and non-occupational illnesses and accidents, paying cash benefits during brief incapacitation

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and also providing for medical care, maternity care and funeral expenses. An average of 6.4 million workers plus 12.9 million dependents were covered.

Employers' Liability Insurance (1931)

Legislation which defined and placed upon the employer in civil engineering, construction and forestry industries responsibility for occupational accidents and illnesses; providing for employer-supported reserve funds from which the employer was reimbursed for medical care, cash benefits for sickness and continuing invalidity (lump sums), funeral and survivors. Estimated coverage 1.25 million workers.

National Health Insurance (1938)

A program which extended the Health Insurance system and sponsored town and village health associations, which were supported by members' contributions and a government subsidy, providing medical and maternity care, and in some instances funeral benefits, to the rural population and self-employed individuals. Although the program was designed originally to merely authorize the organization of associations on a voluntary basis, official pressure led to a revision in the law in 1942 whereby prefectural governors could order the formation of such associations and make membership compulsory. Coverage of family heads and their dependents estimated at 41 million persons.

Seamen's Insurance (1939)

A composite social insurance program for seamen serving in fishing vessels of thirty tons or more and other vessels of twenty tons or more, with contributions divided between ship owners and seamen; provided for both occupational and non-occupational illnesses and accidents and paid cash benefits for sickness and continuing invalidity, funeral and survivors, in addition to old age and medical care. The program covered 92,000 seamen.

Welfare Pension Insurance (Formerly "Workers' Annuity") (1941)

This was a compulsory system of practically the same employees as were covered by Health Insurance, with contributions divided equally between employer and employee; paying old age benefits (beginning in 1956) and cash benefits for continuing invalidity and survivors related to both occupational and non-occupational disabilities. Coverage averaged 6.4 million workers.

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Public Employees' Protection Systems

National Government Pension System (1871)

A retirement law for all national and prefectural (with national status) officials who were career public servants, including policemen and teachers; financed primarily by the government (over 97%); paid cash benefits for occupational invalidity, old age and survivors. Approximately 700,000 civilian employees plus 1.1 million military personnel were protected.

Local Government Pension Systems (1923)

Prefectural, city, town and village systems established by local ordinances for local officials not having national official status; paid benefits similar to those under the National Government Pension System. Coverage estimated at approximately 250,000.

Workmen's Compensation for National Government Employees (1892)

A program based on three Imperial Ordinances (promulgated respectively in 1892, 1918 and 1928) and financed by government funds for all national employees, excluding officials, not covered by Health Insurance, Welfare Pension Insurance, National Government Personnel or Enterprise Mutual Aid Associations; paid cash benefits for funeral and survivors and for occupational disabilities; also provided medical care and paid short-term cash benefits for sickness. Coverage of 1.4 million employees.

National Government Mutual Aid Associations (1907)

National Government Personnel (10 Associations): organizations composed of national and prefectural employees, including officials, not covered by National Government Enterprise Mutual Aid Associations; financed in approximately equal shares by the government and employees; provided for non-occupational accidents and illnesses and paid cash benefits for confinement, funeral and short-term sickness, in addition to medical and maternity care, except that the Teachers' Association also paid occupational invalidity (long-term) benefits. Coverage estimated at 320,000 employees plus 730,000 dependents.

National Government Enterprise (11 Associations): organizations composed of national employees, including officials (except in the Public Works Association), working in enterprises operated by the national government; financed in approximately equal shares by the

government and employees; provided for both occupational (except those covered by the National Government Pension System) and non-occupational accidents and illnesses and paid cash benefits for brief incapacitation, confinement, old age, funeral and survivors, in addition to medical and maternity care. Coverage of 1.5 million employees plus an estimated 3.4 million dependents.

Local Government Mutual Aid Associations (1940)

Local Government Personnel: organizations composed of city, town or village employees, including officials, established by local ordinances; financed and benefits paid according to provisions of the ordinance governing the particular Association, with benefits generally similar to those provided by National Government Enterprise Mutual Aid Associations (except that the six large cities paid long-term benefits to street railway workers). Coverage estimated at 500,000 local employees plus 1.1 million dependents.

Post Office Life Insurance and Annuities

These comprised the Post Office Life Insurance (1916), the Post Office Group Annuities (1925) and the Post Office Annuities (1926).

The Japanese also had a system of Post Office Life Insurance and Annuities, administered by the Ministry of Communication. These programs gave protection of a type comparable to United States life, endowment or retirement commercial insurance policies and provided for death benefits, old age and limited disability. Over 91 million policies had been issued, having a face value of more than 26 billion yen.

Development of the Program

The Labor Advisory Committee to SCAP

As a first step toward the evaluation of the Japanese social insurance programs, the Insurance Bureau of the Ministry of Welfare was directed to submit current statistics on coverage, contributions, benefits paid into reserve funds and related services. In reviewing these data, it was apparent that contributions paid before the end of hostilities far exceeded benefit grants under any of the programs and that the social insurance revenues had been used in part to help defray the expenses of the war.

Shortly thereafter, a group designated as the "Labor Advisory Committee to SCAP" included in its report a review of the social insurance systems and recommended that the following steps be taken:

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1. Safeguard the social insurances against the effects of the post-war currency inflation.
2. Adopt specific measures affecting Health Insurance and National Health Insurance to assure adequate medical treatment.
3. Assure a broader participation by insured people and other groups concerned in the management of these social insurances.
4. Study the need for unemployment insurance and for a separate system providing indemnity and medical care for those disabled because of occupationally caused accidents or illnesses.
5. Assure the development of a program of information and education with regard to social insurances to insure that beneficiaries will be familiar with their rights under existing systems.
6. Study the extension of coverage on those groups not insured under existing programs.

This Committee, finding a serious lack of coordination in existing programs and major problems susceptible to treatment only in terms of legislative changes, expressed the view that a comprehensive reform of social insurance could and should be undertaken and that such action should be taken immediately.

In November 1946 the Public Health and Welfare Section began planning with the Ministry of Welfare in carrying out the recommendations of the Labor Advisory Committee.

The Advisory Council on Social Security

A "Committee for the Investigation of the Social Insurance System" was established in the Ministry of Welfare in March 1946. This was done by a Cabinet Order, drafted by the Japanese Cabinet, which provided that membership be drawn from labor, employers, faculties of leading universities and officials of the Japanese Government. Problems and proposed solutions, with emphasis on consideration of the ability of the Japanese economy to meet any suggested changes, were submitted and analyzed in joint conferences attended by members of this Committee and representatives of SCAP and the Japan Medical Association.

The foregoing Committee was supplanted by the Advisory Council on Social Security, in the Office of the Prime Minister, upon the enactment of legislation by the Diet in December 1948. This action was the outgrowth of recommendations made by the Social Security Mission from the United States which made a study of the social security program in Japan during the latter part of 1947. The Council has the responsibility of making recommendations relative to a social security program to the Prime Minister for submittal to the Diet. It gives written advice as to the most effective methods of providing economic security through social insurance, and as to legislation and administrative policies concerning social insurance and related programs.

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The Council has a membership of thirty persons drawn from the following groups: members of the Diet, officials of government offices concerned, persons of learning and experience, and employers, employees, physicians, dentists, pharmacists, and others similarly participating in the operations of the social insurance programs. The appointments are made by the Prime Minister. In addition, twelve temporary members may be appointed if and when considered necessary.

It is intended that the Council be independent of any individual Ministry and be assured of freedom of expression and research. It is designed to go beyond the social insurances and to encompass the broad field of social security in its deliberations.

Preliminary Adjustments in Existing Programs

Pending agreement upon definite conclusions relative to a unified, comprehensive insurance program, the Ministry of Welfare was advised in May 1947 that the following recommendations should receive immediate attention:

1. Establishment of an informational and educational program for the insured.
2. Establishment of a system of reports covering statistical and financial information.
3. Initiation of a program of research and analysis.
4. Development of a plan for the utilization of the Welfare Pension reserve fund.
5. Study of the possibilities of revising the eligible age for receiving pension benefits.
6. Development of a supervisory plan for assuring proper administration of the various systems from the national to the prefectural and local level.
7. Study of the possibilities of unifying the health provisions of the various systems into one nationwide health insurance program.

The National Health Insurance system has suffered seriously because of inadequate and unsound financing. The Ministry of Welfare was given support in its endeavors to obtain increased national subsidies to rebuild the National Health Insurance medical facilities. The Ministry also was encouraged to make more effective use of existing hospital and clinical facilities and drug supplies and to improve procedures for paying doctors.

In the course of developing the foregoing recommendations, assistance was given to other agencies of the Japanese Government (the Ministries of Finance and Labor, and the Pension Bureau of the Prime Minister's Office), as well as the Ministry of Welfare, in the preparation of new legislation and amendments to existing laws.

New Legislation and Amendments Affecting Social Insurance Laws

Through a Cabinet Decision in March 1947, a program of separation allowances, financed by government funds, was set up for all regular public employees involving an estimated total of 2.7 million employees. Cash benefits are provided for loss of employment and, on the death of a worker, for his survivors.

Based upon the provisions of the Labor Standards Law, which fixes liability of the employer for occupational accidents and illnesses, the Workmen's Accident Compensation Law was developed in cooperation with the labor Division of the Economic and Scientific Section of GHQ, SCAP, and became effective 1 September 1947, upon which date the Employers' Liability Insurance Act was repealed. Coverage is estimated at 6 million and extends generally to concerns employing five or more persons but in certain hazardous occupations includes undertakings employing only one worker. Government workers and seamen are excluded.

The Seamen's Insurance Law was amended to assure compliance with the occupational accident compensation provisions of the new Mariners' (Labor Standards) Law, affording protection similar to the land workers' Workmen's Accident Compensation Law. At the same time, coverage was increased under the Seamen's Insurance Law through extending its provisions to crews in ships of five tons or more (although no change was made with reference to tonnage limitations of fishing vessels covered).

With the advent of the Workmen's Accident Compensation Law, the Health Insurance law was amended to restrict its field to non-occupational illnesses and accidents. The Welfare Pension Insurance Law was revised to remove the distinction between provisions for occupational and non-occupational disabilities and to exclude claims for the period (maximum of six years) compensated under Workmen's Compensation.

The Unemployment Insurance law, also developed in cooperation with SCAP's Labor Division, became effective 1 November 1947. Firms employing five or more persons and engaged in industries other than shipping, construction, agriculture or the rendering of domestic service come under the law. Coverage is now estimated at 5.3 million. Similar provisions were added to the Seamen's Insurance Law to provide unemployment benefits for seamen.

The Undemobilized Persons' Compensation Law was enacted in December 1947 to prescribe the amounts of compensation (pay and family and traveling allowances) to be paid to undemobilized persons (military and civilian employees of the former army and navy) when they are repatriated and to their dependents pending repatriation. This law was amended in December 1948 to increase the amounts of compensation, provide medical care for those in need thereof after demobilization, and provide disability allowances for those not covered by the Government Pension System, when the need for such care or disability resulted from causes occurring prior to repatriation.

Provisions have been written into each social insurance law to prescribe appeals and fair hearing procedures and the facilities established have begun to function. A full-time referee has been appointed in each prefecture to hear appeals under the Health, Welfare

Pension and Seamen's Insurance Laws, and separate central appeals boards have been appointed for each of these programs to receive appeals from the referees' decisions. Similar provisions have been made with respect to the Workmen's Accident Compensation and Unemployment Insurance Laws. Prefectural appeals boards have been formed to hold hearings under the National Health Insurance Law. Referees are assigned the collateral duty of conducting information services to acquaint the public with the right of appeal. Provisions for appeals board have been included in the National Public Service Mutual Aid Association Law, but the National Government Pension System continues to designate the Prime Minister as the addressee of appeals under that program.

In the course of Diet action taken in June 1948 to transfer substantive matters from cabinet orders and ministerial ordinances to statutes, the National Public Service Mutual Aid Association Law was enacted. The provisions of the 13 Imperial Ordinances (cabinet orders) providing for National Government Mutual Aid Associations were incorporated into one law providing uniformity of coverage for employees of the national government. The chief of the government agency within which an Association is formed is responsible, with the assistance of a Managerial Committee, for the administration of the Association. While some of the Imperial Ordinances provided for both occupational and non-occupational disability benefits, this law provides benefits for off-duty causes only.

The Minister of Finance has proposed a separate program for providing accident compensation for all government workers. The three Imperial Ordinances which constituted the workmen's accident compensation program for national public service employees became inoperative in July 1948, when cabinet orders not specifically authorized by a given statutory law were declared to be no longer effective. Pending Diet action on the proposed accident compensation law, public employees derive their protection directly from the provisions of the Labor Standards Law.

Although there is some overlapping of the Mutual Aid Association program and that of the National Government Pension System, and the Seamen's Insurance law (which covers all seamen including government employees), the enactment of the National Public Service Mutual Aid Association Law and the proposing of a law for uniform coverage for accident compensation for all government employees denote steps toward unification and simplification of the laws relating to national public service employees and toward the further objective of attaining one comprehensive system for all persons to be covered by social insurance.

In August 1948 the Local Government Mutual Aid Societies were re-organized as Health Insurance Societies. The National Public Service Mutual Aid Association Law provides that its coverage may be extended to the Local Government Associations. The Health Insurance Law, by amendment in 1948, includes public employees who are not members of a National Public Service Mutual Aid Association. Because of the expressed desire of the six largest cities in Japan, it was agreed to limit the extended coverage of the Mutual Aid Law to prefectural employees and that the Health Insurance Law would cover employees of all cities, towns and villages.

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In July 1948 the comprehensive revision of the National Health Insurance Law, assigning basic responsibility to the local public bodies for the administration of pre-paid medical care for those residents not otherwise protected, was completed. This amendment represents the results of research and planning by the Ministry of Welfare, in conjunction with representative advisory bodies, prompted by the continuing difficulties this program has had to contend with since the closing days of the war. Emphasizing the community character of the program, the amendments should provide a firmer basis for its operation.

Ceilings on taxable wages were raised and the definition of the taxable wage was broadened to take into account the numerous bonuses and allowances traditionally paid in addition to the basic wage. These changes were designed to equalize the burden among the insured, take a more realistic view of the current economy, and approach a standard for the various programs. Amendments passed by the Diet in 1948 provided for substantial increases in existing and future invalidity and survivors' benefits and additional benefits for the invalid's spouse and children. Medical and funeral benefits under the Seamen's Insurance Law, heretofore limited to only the insured seaman himself, have been made available to his dependents.

In addition to the Advisory Council on Social Security, individual advisory councils have been established by law for each of the social insurance programs. Membership will be drawn from representatives of the insured, the insurers, employers, the medical profession and the individuals designated as representing the public interest. Each of the programs except National Health Insurance will have a council on the national level. The National Health Insurance Law, however, provides for an advisory council in each city, town or village administering that program. Questions may be considered on referral by interested agencies or through initiation by the council itself, and an annual report will be published by each council.

Two agencies, each known as the Medical Fee Calculating Committee, have been established at the national level. One is to advise the Minister of Welfare on the determination of appropriate medical care fees for Health Insurance and Seamen's Insurance; the other to prescribe standards or guides for the setting of medical care fees for National Health Insurances.

Designated to expedite payments to doctors, dentists and pharmacists, the Social Insurance Medical Fee Payment Fund Law was enacted by the Diet in July 1948. A central office in Tokyo and branch offices in each of the prefectures have been established to handle the operations of the Fund. The insurer participating (participation is not compulsory but is expected to be general in view of the demands of the medical profession for more prompt payment of its medical care claims) will have on deposit in the Fund an amount sufficient to meet its monthly medical care claims. The Fund receives all claims by insurance doctors for medical care given to the insured through programs under direct government management. Participation in the Fund is optional for the other programs. All Health Insurance Societies and almost all the National Public Service Mutual Aid Associations have availed themselves of this option. The Fund is designed to make prompt and appropriate payment of the claims as calculated in accordance with the medical care fee schedule determined by the Minister of Welfare.

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Heretofore survivors' pensions were subject to the same qualifying periods as applicants for old age pensions. Under the Seamen's Insurance and Welfare Pension Insurance Laws the surviving spouse and children of a worker insured for 6 months, rather than the respective 15 or 20 year qualifying periods, may be eligible for benefits.

Through revision in November 1948 of the Ministerial Regulation drafted by the Minister of Welfare in accordance with the Government Organization Law of 1948, two new Sections, the Medical Section and the Actuarial and Statistical Section, were established in the Insurance Bureau in addition to the five existing Sections: General Affairs, Health Insurance, National Health Insurance, Welfare Pension Insurance and Seamen's Insurance. The establishment of a Medical Section provides for consolidating the supervision of medical affairs as they apply to the various social insurance programs. The Actuarial and Statistical Section provides for centralizing studies concerning the actuarial insurance principles and statistics for a coordinated social security system.

As indicated by the Section designations, the Ministry of Welfare's direct responsibility is for the Health Insurance, National Health Insurance, Welfare Pension Insurance and Seamen's Insurance programs. The Workmen's Accident Compensation Insurance and Unemployment Insurance Laws were assigned to the Ministry of Labor upon the creation of that Ministry in 1947. The National Public Service Mutual Aid Associations and the program of separation allowances for public employees are under the supervision of the Ministry of Finance.

Charts 25 and 26 summarize the coverage and financial provisions of the social insurance laws now in effect as well as collections and the benefit disbursements during the calendar year 1948.

Statistics and Reports

In order to improve social insurance operational statistics and reporting in regard to adequacy and timeliness, assistance was given to the responsible Japanese officials in overhauling and enforcing reporting requirements. Plans were worked out for the gradual expansion of the list of data reportable under the several programs and for their coordination with a view to periodic publication, eventually, of unified social insurance statistics. As a first step toward this end, the Insurance Bureau, Ministry of Welfare, has started to publish, in both Japanese and English, a monthly report on operations under the programs for which it has responsibility.

The Social Security Mission

Upon SCAP invitation, a Social Security Mission from the United States arrived in Japan in September 1947 to compile a study of existing social security legislation and administrative practices in Japan, for the purpose of making recommendations to improve the social in-

SOCIAL INSURANCES AND RELATED PROGRAMS

LAW	COVERAGE CLASSIFICATION		ADMINISTRATION	FINANCING	BENEFITS
	NUMBER				
HEALTH INSURANCE (1922)	5,100,000 PLUS 11,700,000 DEPENDENTS	INDUSTRIAL WORKERS	SOCIETIES OR GOVERNMENT	EMPLOYER-EMPLOYEE EQUALLY PLUS GOVERNMENT SUBSIDY	CARE: MEDICAL, MATERNITY. CASH: SICKNESS, MATERNITY, FUNERAL.
NATIONAL HEALTH INSURANCE (1936)	32,000,000	MOSTLY RURAL FAMILIES	LOCAL GOVERNMENT AND ASSOCIATION	INSURED PLUS GOVERNMENT SUBSIDY	CARE: MEDICAL, MATERNITY. CASH: FUNERAL.
SEAMEN'S INSURANCE (1939)	100,000 PLUS 200,000 DEPENDENTS	SEAMEN	GOVERNMENT	EMPLOYER-SEAMAN CONTRIBUTION (65 : 35) + GOVERNMENT SUBSIDY	CARE: MEDICAL. CASH: SICKNESS, INVALIDITY, OLD AGE, UNEMPLOYMENT, FUNERAL, SURVIVORS.
WELFARE PENSION INSURANCE (1941)	5,100,000	INDUSTRIAL WORKERS	GOVERNMENT	EMPLOYER-EMPLOYEE EQUALLY PLUS GOVERNMENT SUBSIDY	CASH: INVALIDITY, OLD AGE, SURVIVORS.
UNEMPLOYMENT INSURANCE (1947)	5,300,000	INDUSTRIAL WORKERS	GOVERNMENT	EMPLOYER-EMPLOYEE AND GOVERNMENT IN EQUAL PARTS	CASH: UNEMPLOYMENT.
WORKMEN'S ACCIDENT COMPENSATION INSURANCE (1947)	6,000,000	INDUSTRIAL WORKERS	GOVERNMENT (CENTRAL)	EMPLOYER	CARE: MEDICAL. CASH: SICKNESS, INVALIDITY, FUNERAL, SURVIVORS.
GOVERNMENT PENSION SYSTEM (1871)	600,000	OFFICIALS	GOVERNMENT	PRIMARILY GOVERNMENT (APPROXIMATELY 97:3)	CASH: INVALIDITY, OLD AGE, SURVIVORS.
WORKMEN'S COMPENSATION FOR GOVERNMENT EMPLOYEES (1892)	2,700,000	OFFICIALS, ADMINISTRATIVE EMPLOYEES	GOVERNMENT	GOVERNMENT	CARE: MEDICAL. CASH: SICKNESS, SURVIVORS.
GOVERNMENT MUTUAL AID ASSOCIATIONS (1907)	1,000,000 PLUS 2,700,000 DEPENDENTS	OFFICIALS, ADMINISTRATIVE EMPLOYEES		GOVERNMENT AND EMPLOYEE EQUALLY	CARE: MEDICAL, MATERNITY. CASH: SICKNESS, CONFINEMENT, FUNERAL.
ENTERPRISES	1,100,000 PLUS 2,700,000 DEPENDENTS	GOVERNMENT MONOPOLY EMPLOYEES	ASSOCIATIONS	GOVERNMENT + GOVERNMENT SUBSIDY	CARE: MEDICAL, MATERNITY. CASH: SICKNESS, CONFINEMENT, OLD AGE, FUNERAL, SURVIVORS.
GOVERNMENT SEPARATION ALLOWANCES (1947)	2,700,000	ALL PUBLIC WORKERS	GOVERNMENT	GOVERNMENT	CASH: UNEMPLOYMENT, SURVIVORS.

PRELIMINARY STATEMENT OF SOCIAL INSURANCE CONTRIBUTIONS & BENEFITS: JAPAN, 1948

INSURANCE PROGRAM	CONTRIBUTIONS COLLECTED	TOTAL BENEFIT COST	MEDICAL & ALLIED CARE BENEFITS*	
			CASES +	AMOUNTS
HEALTH INSURANCE	6,952,117,675	6,499,474,969	10,884,911	4,474,228,150
NATIONAL HEALTH INSURANCE *	1,390,467,964	1,100,660,220	4,536,114	1,095,000,000
SEAMEN'S INSURANCE	503,654,392	247,830,577	208,094	168,860,310
WELFARE PENSION INSURANCE	4,258,224,720	210,518,751	--	--
UNEMPLOYMENT INSURANCE	3,726,627,109	158,724,962	--	--
WORKMEN'S ACCIDENT COMPENSATION INSURANCE	1,889,027,777	1,745,684,548	427,657	456,593,874
GOVERNMENT PENSION SYSTEM	244,021,365	166,968,764	--	--
GOVERNMENT MUTUAL AID ASSOCIATIONS	3,266,602,706	3,161,624,238	13,047,266	1,304,940,131
TOTAL	22,230,743,708	13,291,487,029		7,499,622,465

* DATA INCOMPLETE.

** IN KIND OR CASH.

+ CASE FIGURES ARE NOT COMPARABLE BETWEEN PROGRAMS DUE TO CONSIDERABLE

+ ESTIMATED IN PART.

Δ ESTIMATED.

VARIATION IN DEFINITIONS.

Public Health and Welfare in Japan

insurance and medical care benefits for the Japanese people.

The Mission spent sixty days in Japan during which time a series of conferences were held with the Japanese Committee for the Investigation of Social Insurance, Japanese Government officials, representatives of the Japan Medical Association, representatives of Japanese industry, workers and professions, and with representatives of the various social insurance plans. During this period, visits were made to a number of insurance institutions, as well as public and private facilities which were caring for patients under provisions of the social insurance laws, in order to get a complete picture of the overall program throughout the nation.

In connection with the visit of this Mission, extensive research was undertaken regarding the economic and financial basis of Japanese social security programs. Studies were completed involving statistical analysis of the past experience of social insurance schemes now operating, as well as actuarial and cost estimates of the future burden of selected programs under varying assumptions of coverage, scope and general methods of administration.

Their report, which has been reviewed and analyzed by interested SCAP sections, was accepted by SCAP on 3 July 1948, and turned over to the Japanese Government for use as a document of reference and study concerning current social insurance programs. The report has been translated and published in Japanese by the Ministry of Welfare, distributed to all prefectural governments and made available at a nominal charge to the general public.

Following acceptance of the Mission's report by SCAP, instructions were dispatched to the Military Government Teams stating that "The maintenance of a comprehensive and adequate social security program based on democratic precepts and within the limits of the nation's resources has been designated as an approved Occupation objective." Military Government Teams were requested to aid in attaining the stated objective by giving review and guidance to the prefectural and local levels of administration of the social insurances to insure the inclusion of democratic processes and effective and economic operations. It was requested further that monthly reports be made of the results of such activities, with such advice and suggestions as may appear desirable in appraising the entire program and for guidance in reviewing measures proposed by the Japanese Government.

Several laws which were in preparation at the time the report was compiled, and which have since been passed by the Diet, incorporate a number of the leading recommendations of the Mission. Among such laws are the Health Center Law, the Medical Service Law and the Immunization Law. As a result of the report, as noted above, the law establishing the Advisory Council on Social Security has recently been enacted.

Other recommendations included integration of all present obligatory social insurances into one basic system to provide uniform protection, and a strengthening of health insurance for other than industrial wage earners by providing community health plans at the choice of the citizens. The report further recommended that reforms be patterned to Japanese needs and cautioned the danger of attempting

to copy existing programs in other nations without consideration of the basic differences in those nations' social structures.

The American Medical Association Mission

At the invitation of SCAP, a mission composed of members of the board of trustees and officers of the American Medical Association visited Japan during August 1948 to review and make recommendations on social security and insurance programs with particular reference to medical care aspects. The Mission reviewed all elements of medical care in both urban and rural areas and gave material assistance in promoting professional ethics and standards and democratic ideals among the members of the medical profession of Japan.

The report made to SCAP at the conclusion of the visit, has been given to the Japanese Government, the Japan Medical Association and other public and private Japanese agencies as a document of advice and reference in reviewing and formulating changes in the public health and welfare programs. In the course of their report, the AMA Mission reviewed the recommendations made by the Social Security Mission. In referring this report to the Japanese, it was stated that any differences of opinions reflected in the recommendations of the two Missions are to be considered by the Japanese and the decision made by them as to what course will be followed.

The AMA report expressed agreement with the aim of the Social Security Mission to give the Japanese people better medical care and with many of the conclusions of that Mission, but indicated differences as to some aspects of the means to be employed in achieving the objective. The report stressed that SCAP has been faced with the problem of establishing de novo the principles and organization of a democracy among a people subjected for centuries to the domination of a totalitarian government. "In our opinion, the (Japanese social security) system has failed under a totalitarian government and cannot succeed unless organized on democratic rather than socialistic principles."

There was agreement with the Social Security Mission's statement that the proper functioning of the health insurance systems is dependent upon the strict observance of the agreed upon rates of payment for services and that "the greatest possibility for achieving that essential condition is to have the arrangements made locally between representatives of local interests, who realize fully what the insured people can pay, who recognize the value to the insured group of pre-paid medical care, who have a sense of responsibility to the insured group, and who can, on a day-to-day basis, enforce an observance of the agreements." The AMA report noted that "part of the complaint of the physicians is that, while they might have been satisfied with the fee-schedule at the time they earned the money, during the period of inflation their remuneration was delayed" for excessive periods, with a resulting diminishing value of the money paid.

The AMA Mission disagreed with the recommendation of the Social Security Mission that the present method of paying doctors on a fee-for-service basis has serious drawbacks and that effort should be

directed to experiment with other methods of payment. The AMA Mission stated opposition to the capitation or salary methods of payment and prophesied an "inevitable deterioration of quality of service when it is rendered under salary by government employees."

While recognizing the necessity that some agency of the executive branch of the national government be charged with the responsibility of over-all supervision in the execution of the health insurance laws, the AMA Mission's report put greater emphasis on the need for decentralizing administration to the prefectural and local levels, subject to the will and desire of local groups to reflect their needs under local autonomy. The AMA Mission indicated the belief that, "wherever possible, members in the health insurance programs should be voluntary and should arise from a general recognition on the part of the Japanese people that such protection is both desirable and economical."

Future Plans

Major consideration in the immediate future will be given to three projects:

1. Assistance to the National Advisory Council on Social Security.
2. Assistance to Military Government Teams in fulfilling their responsibilities with regard to the social insurances.
3. Continuation of consultations with Ministry of Welfare and local officials in reviewing administration and drafting legislation.

When an agreement is concluded on the framework of an adequate, coordinated and soundly financed social security program, efforts will be directed along two main lines; (1) implementation of the plan through appropriate legislation and ordinances, and (2) surveillance of the Japanese Government agencies' administration of the social insurance programs to insure they are carried out effectively and efficiently.

Sound administrative procedures seem to be a special need in the Japanese Government agencies. In implementing the Japanese social insurance program, special attention will have to be given to the following:

1. Adequate information to insured people as to their rights and obligations under the law.
2. Extension of the scope, authority and public representation on committees established by the government for advisory and review purposes.
3. Administrative supervision of operations from the national as well as from the prefectural level. The government will need an adequate and qualified field force. The process of supervision will include statistical reporting and standardization of procedures to assure effective administration at all levels.

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4. Coordination and cooperation between the government insurance officials and the Medical Association in raising the standards of medical services to the insured.
5. Acceptance and exercise of responsibility in the local areas of government.
6. A simplified and non-partisan method for more frequent use of appeal privileges to assure proper administration and greater individual participation in the program.
7. Development of modernized grant-in-aid methods to govern national and local government subsidies to the several programs now operating, especially National Health Insurance in its revised form, with a view to relating such subsidies to minimum standards of performance, comparative need and fiscal ability.

Economic trends in employment, wages, national income and production will continue to be evaluated in the light of their effect on the reasonableness of the social insurance provisions for compensation of wage loss, adequacy of provisions for paying the costs of medical services, the adequacy of the provisions for financing the system and of existing reserves. Continued evaluation will also have to be made to the outlook for changes in major economic indices, as a guide in judging the proper scope and adequacy of all benefits provided, or to be provided, and possible corrective action.

Especially in connection with the implementation of a recent SCAP order directing the Japanese government to stabilize the country's economy according to the lines laid down in a nine-point program released by the U. S. Government, some of the social insurances may be subjected to a severe test regarding their adequacy and smooth functioning. During the crucial period which is expected to be characterized by, among other things, substantial, if temporary, retrenchment in employment, special attention will have to be given to any gaps and weaknesses appearing in the present social security system and speedy enactment of such modifications as seem indicated for their prompt remedy.

At the same time, an effort will be made to aid in the realization of the aims of the nine-point stabilization program by effecting economies in social insurance administration. The recommendations made by the Social Security Mission include plans to this end in the form of proposals for a unification of several separate programs, a single tax for social insurance purposes and central collection thereof with ensuing savings in overhead to employers as well as to the government. These plans are to be studied shortly by the Social Security Advisory Council and, if they are reported favorably, Diet action thereon is expected during 1949.

Chapter 8

NUTRITION

Pre-surrender Analysis

Historically, Japan has always had a food deficit. With a population now of 80,200,000 (est. 1 July 1948) and limited areas for production (only 16% arable), she has been dependent on food imports amounting to at least 15% of her requirements. Normally, the diet is basically composed of rice, fish and fresh seasonal vegetables.

The war did not create problems in nutrition but only emphasized the inadequacy of the indigenous food supply, consequently the curtailment of imports and shortages of the necessary food nutrients are directly related to the health of the civilian population.

During the war with China and later World War II, the Japanese people were on a restricted ration diet which became more severe as the war progressed and imports were curtailed. The military had saved and stored large quantities of foodstuffs for their food requirements, leaving the civilian population deficient in their normal food rations.

The inadequacy of the ration was partially met by home gardening. Physical examinations carried out in the nutrition surveys during the period of food shortages evidenced an increase in a proportion of individuals with symptoms associated with malnutrition. The surveys also indicated that underfed children, especially of urban areas, resulted in lowered height and weight compared with the years previous to 1941. (Ref. chart 27)

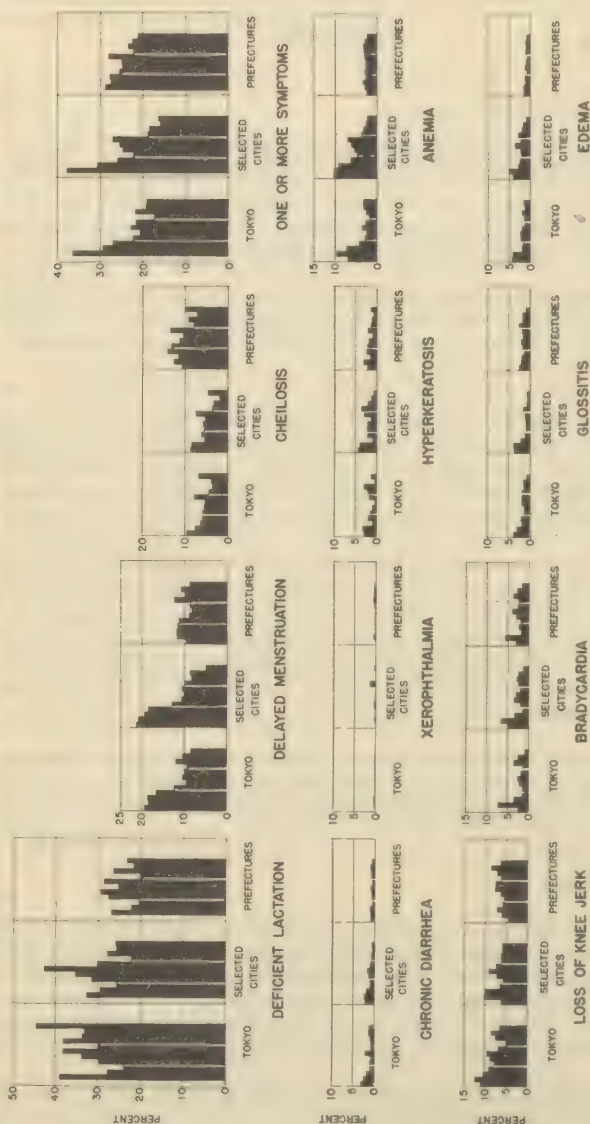
The resultant confusion of the capitulation caused disorganization of the existing ration system; lack of transportation prevented adequate distribution of the meager food supplies available.

Nutrition Programs

An accurate appraisal of the Japanese food situation was dependent upon data concerning the nutritional status of the population and information as to the actual food consumption. As the official ration level (until the present) was below the minimum subsistence level, it was anticipated that consumers would supplement ration issues by home production, gifts and purchase of non-rationed food.

Realizing the need for factual information to help clarify the food situation, instructions to the Japanese Government, directed a nutrition survey be conducted in Tokyo in December 1945. Tokyo was selected initially because it was in this area where rumors were rampant on deaths occurring due to starvation. In February 1946, the cities of Nagoya, Osaka, Kure were added. Sapporo, Sendai, Kanazawa and Matsuyama were included in May 1946. In addition, an equal number of people were surveyed in the rural area of prefectures surrounding these cities.

DEFICIENCY SYMPTOMS, ACCORDING TO NUTRITION SURVEYS IN TOKYO, SELECTED CITIES AND PREFECTURES-JAPAN, 1945-1949



LEGEND
MONTH DEC. MAY. AUG. NOV. FEB. MAY. AUG. NOV. FEB. MAY. AUG. NOV.
YEAR 1945 1946 1947 1948 1949

Chart 27

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These initial nutrition surveys covered Tokyo and eight large cities (Nagoya, Osaka, Kure, Fukuoka, Sapporo, Sendai, Kanagawa and Matsuyama). They were and are at present still conducted every three months (February, May, August and November).

The surveys also include physical examinations for purposive sampling of communities for certain symptoms associated with nutrition deficiencies, including body weights and heights. In addition, the food consumption was obtained on one-half the number of people given physical examinations.

The total number of individuals examined every three months for surveys conducted from December 1945 through November 1947 averaged about 150,000. This represented approximately 1% of the population in these designated areas who were representative of all age groups and all economic groups.

These nutrition surveys conducted from 1945 through 1947, proved of such paramount importance as a means of obtaining desirable information on production, distribution, consumption and various other data regarding the food picture in Japan, that it became necessary to improve the sampling and include a wider area of survey. Thus in February 1948 the nutrition surveys were revised and expanded to include a random sampling of twelve large cities (Tokyo, Nagoya, Osaka, Kure, Fukuoka, Sapporo, Sendai, Kanagawa, Matsuyama, Yokohama, Kobe and Kyoto) with a population of 30,000 or more, and the entire 46 rural prefectures. Physical examinations including body weights and heights, as well as eleven symptoms associated with nutritional deficiency, are obtained on all the people surveyed (approximately 42,000). In the initial surveys (1945-1947), food consumption studies were done only on one-half of the people given physical examinations whereas the revised surveys (1948) now include detailed consumption studies on the total number of people examined.

Surveys conducted prior to 1948 were based upon a random sampling procedure. They were selected on the purposive basis and therefore were not as representative as the surveys conducted in February 1948.

For analytical purposes, the country was divided into three strata, namely the twelve largest cities, all other cities, and the prefectural or rural areas. Although the earlier surveys included nine cities besides Tokyo, data collected under the new method can be compared with it.

The surveys conducted in the towns and villages may be considered representative of such areas. In surveys made before 1947, 27 prefectures were included. Comparisons can still be made with data obtained in the new surveys (46 prefectures).

Through the use of random sampling methods the desired information can be obtained from a smaller number of households. The results are more reliable, the data more quickly obtained and with fewer field personnel.

The cost of making this survey under the revision of 1948, will not be increased, even though it is conducted over the entire area of Japan. Furthermore, the fact that they are taken in all parts of the country, will serve to increase the interest and understanding of them.

Public Health and Welfare in Japan

Results of these surveys under close supervision of SCAP are considered reliable, having been comparable from survey to survey. (Ref. charts 28, 29)

The Results of the Surveys

Variations in food intake resulting from the seasonal availability of indigenous food crops are shown by the nutrition surveys. In the fall and winter months following the harvest of the rice and sweet potato crops, the consumption has risen, while during the summer months food intake falls off sharply with the depletion of stocks of staple foodstuffs.

The per capita caloric intake in Tokyo in December 1945 of 1,971 calories largely was the result of consistently high consumption of sweet potatoes during the fall months. The production of sweet potatoes, which yield very high food values per unit of land, has been expanded considerably in recent years but, due to the limited processing and storage facilities, difficulty is experienced in attempting to store sweet potatoes beyond January.

The nutrition surveys conducted in the four cities in February 1946 indicated a much lower food intake than had prevailed in Tokyo during December. Tokyo was not included in the February survey.

The subsequent nutrition surveys in May, which included the eight cities and Tokyo, indicated a definite decrease in food consumption for Tokyo largely as result of the curtailment in ration distribution at that time. There was a slight decrease in caloric consumption for the cities surveyed in May which had been included in the previous February survey.

The August 1946 survey indicated an improvement in the city of Tokyo because the staple food ration was supported with imported food. The caloric consumption in the eight cities continued to decrease, 1,567 calories, and in four of the large cities fell to approximately 1,300 calories. This decrease in food intake in August was due to a curtailment in the ration distribution which had been largely confined to Tokyo and the other major deficient areas in May, but became widespread throughout the nation in July and August as indicated on chart 28.

In November 1946 the caloric intake increased in all cities with the harvest of the rice and sweet potato crop. In February 1947 the caloric intake was slightly lowered due to the gradual depletion of food stocks from the previous fall harvest.

The nutritional surveys in May 1947 indicated a substantial drop in food intake reflecting the curtailment in ration distribution in certain areas and the reduced availability of food supplies from home gardening and black market sources. August 1947 survey still continued to show a decrease in total caloric consumption. However, the following survey month, November 1947, the usual caloric increase was evidenced in all areas (urban and rural) due to the abundant sweet potato crops and an increase of the official ration from 2.3 go to 2.5 go. Throughout 1948, the nutrition surveys showed a large increase in

URBAN AND RURAL NUTRITION LEVELS

CALORIES - JAPAN, 1946-1947-1948

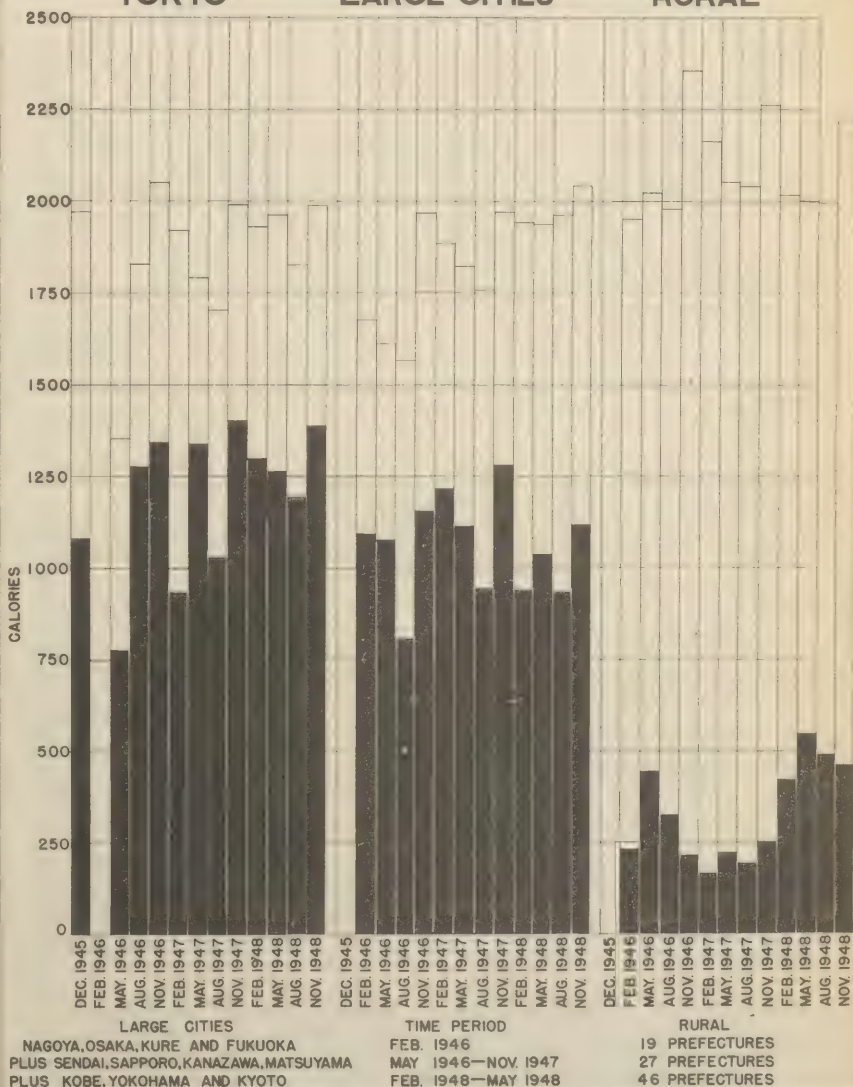
FROM NUTRITION SURVEYS

□ TOTAL
■ RATION

TOKYO

LARGE CITIES

RURAL

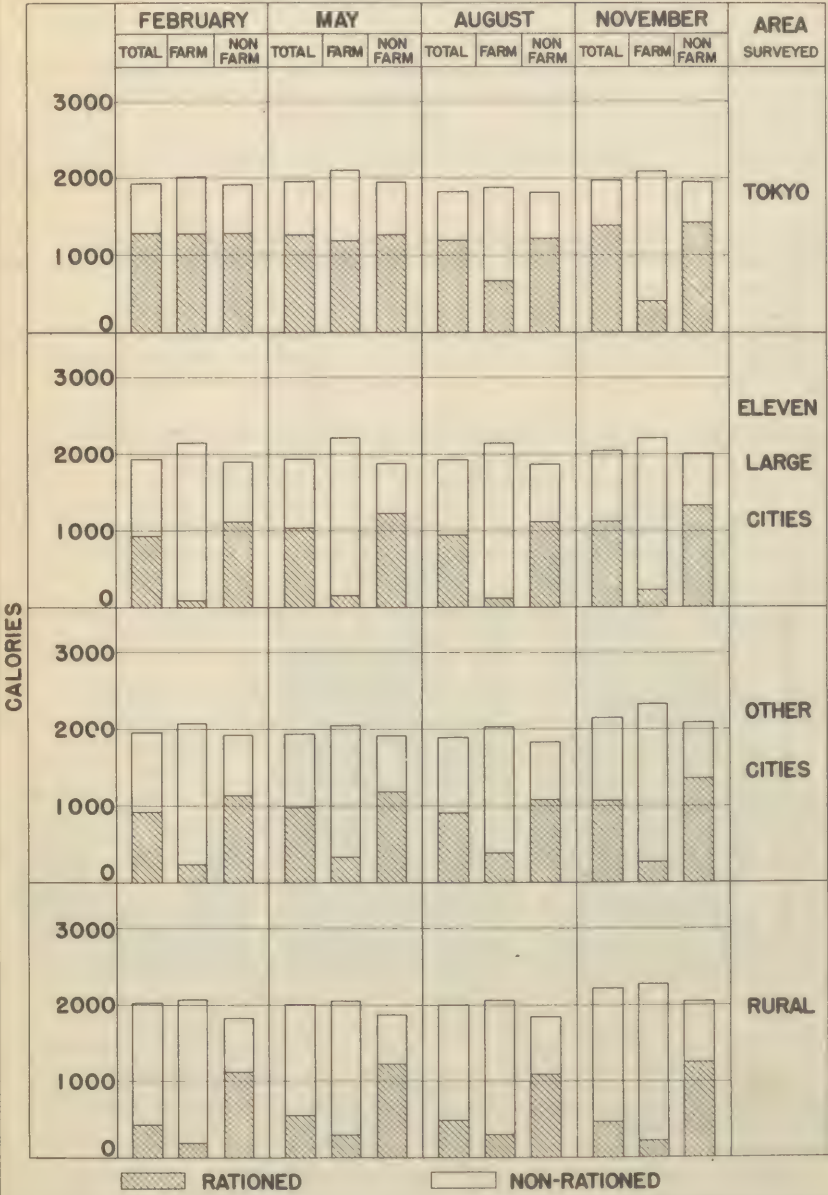


(28)

Chart 28

CALORIC CONSUMPTION IN JAPAN

NUTRITION SURVEYS IN 1948



(29) PH&M/12 CHART NO D-12 7-4-1948

caloric intake in all urban areas over that of 1947. In the same period, very slight changes were made in rural areas over 1947. The nutrition data and the amount of various classes of food consumed show the extent to which the Japanese depend upon grain productions and roots for their energy and the very meager quantities of animal proteins and soy beans available for their diet. Also indicated is the very low sugar and fat content in their dietary.

The rural areas have lived, in relation to normal consumption, at a moderately low but uniform food intake level throughout the year. There has been in both rural and urban areas definite increases in caloric intake, evidenced by November surveys, directly related to the high sweet potato crop. No increase of the quantity of grain products are noticed in November even though available to the farmer. This is due to the planned storage of the grain to be held and not put in distribution until the period during the summer months when critical food shortages are accentuated. Indications are that the food situation has generally improved (Ref. chart 28).

The results of the physical examinations of the population indicated a change in the proportion of individuals with symptoms associated with nutritional deficiencies during the worst period of food restriction. In May 1946 there were slight increases in individuals with anemia, loss of knee jerk and bradycardia in both cities and rural areas. These symptoms are often associated with a deficiency of the vitamin B complex.

There is a seasonal (May and August) drop in the vitamin B¹ content of rice and the lack of supplemental foods, including vegetables, during the winter may have been as much a cause of the increase in physical symptoms as the decreased food supply.

Since May 1946 the nutritional surveys have indicated a decrease in the number of individuals with symptoms related to nutritional deficiencies, particularly with reference to weight loss. The result of the weighings indicates that there was a rather high percentage of young children and individuals over 30 whose body weights were at least 10% less than the standard weight. In August 1947 there was a general increase in the percentage of individuals in all age groups whose body weights were at least 10% less than the standard weight. The results in November 1947 compared similarly to the data obtained in May 1947.

In 1948 there was a slight decrease in the percentage of individuals whose body weights were more than 10% under the standards. In August 1948 the usual percentage of body weights below the standard were evidenced due to the seasonal shortages of food. November 1948 surveys evidenced the percentage of body weights decreased more than 10% below the standard weight (Ref. chart 27).

During the May 1948 surveys, the second under the new revised plan, a distinction was made in both the urban and rural areas between the farming and non-farming groups. The higher caloric intake of the first group, as indicated in chart 29, is due to the food retention allowances permitted the farmers. It is interesting to note that the non-farmer group of Tokyo and the 11 large cities contribute almost as much home production as the farmer group. The definite increase in

the amount of animal protein consumed as shown in the February through November 1948 surveys over the previous years can be attributed to the continued effort being made to increase the flow of fish through official distribution channels.

Physical examinations show an increase in the proportion of individuals having symptoms associated with nutritional deficiencies during the May and August 1948 surveys. Individuals in both cities and rural areas had increases in anemia, edema, loss of knee jerk, glossitis, chronic diarrhea and bradycardia. As indicated in previous surveys, these deficiencies are attributed to lack of vitamin B complex and inadequate amounts of essential food nutrients. Gradual decrease of these symptoms are noted during November 1948 in Tokyo and the rural areas. In the other cities, there were slight increases.

Nutritional deficiencies of the Japanese population are also the result of the inadequacy of certain essential food nutrients in their diet over a long period of time as well as their dependence upon cereal foods. This is particularly true of the age groups 6 to 10 years and 11 to 15 years.

Use of Imported Foods

The Japanese people have been on a limited food consumption for a period of over seven years and showed, as a result, the mental lethargy and inability to carry out prolonged physical labor characteristic of chronic malnutrition. A study made on the labor output in relation to food consumption among coal miners indicated that the tonnage per miner dropped from 14 tons per day to 5.3 tons per day as the caloric intake decreased. Nutrition surveys taken in 1948 indicate substantial increases of symptoms associated with nutritional deficiencies of the four coal mines and copper mines studied.

Surveys conducted on children in the schools has shown retarded growth, both in height and weight as compared to normal standards of height and weight in relation to ages. However, special studies conducted on school children who were given certain essential foodstuffs (animal protein, calcium, etc.) evidenced how physical development and health could definitely be improved by dietaries containing powdered skimmed milk or other forms of animal protein.

Imports of food, therefore, have been necessary to raise the caloric intake of the Japanese people to a minimum subsistence level as well as to prevent disease and unrest.

The use of imported food, however, presented new and difficult problems to the Japanese as at times it has been necessary to issue soy flour, corn flour, wheat flour, milo and currently sugar as the main staple food for families for periods of a week or more. The issuing of food in forms heretofore unknown to the Oriental taste has required a revision in the methods of preparation in cooking, as compared to rice, and the use of more fuel which is still in short supply.

An extensive consumer education program has been undertaken to in-

sure that the people unfamiliar with imported foods can efficiently utilize these rations. Japanese nutritionists have experimented with these foods and subsequently prepared educational information for the civilian population. The radio, magazines, newspapers and other media are being used to reach the Japanese housewives. Nutritionists in the health centers as well as those employed in the various prefectures are also participating in this educational program by giving lectures and practical demonstrations in their respective areas.

With the large shipment in 1948 of corn products (foods not too well accepted by the Japanese), it became evident the diet education must be intensified and extended to the utmost and raised to new heights of effectiveness if the consumer was expected to utilize this and other items of food imports to the best advantage. As a result, the Nutrition Section of the Ministry of Welfare, in cooperation with the Foods Branch of the Ministry of Agriculture and Forestry, organized several teams of nutritionists in 1948 to conduct large scale demonstrations on correct methods of preparation and utilization of imported or unfamiliar foods. Meetings are held every three months in large urban areas (Tokyo, Hokkaido, Kyoto, Fukuoka, Nagasaki) where nutrition leaders personally conduct active demonstrations of tested food recipes. Other home economists, nutritionists and housewives from the areas nearest the above-mentioned cities attend the meetings and then return to their home prefectures and conduct demonstrations of these same food formulas. This step by step visual home demonstration seems to be more effective than other methods of nutrition education.

The National Food and Nutrition Council

This council, reorganized in December 1946, consists of not more than 30 members and includes the Prime Minister as President in addition to representatives of the various ministries of the government concerned with food and nutrition problems. Also included are private individuals technically trained and experienced in food, agriculture, education, public health and economic affairs.

The council holds regular meetings to discuss the over-all nutrition problems of the nation and has been very helpful in speeding up ration distribution and in eliminating certain administrative irregularities in the ration plan.

Several of its members (including a nutritionist) have been invited to attend the First International Rice Conference of the United Nations Food and Agriculture in Bangkok, Siam in March 1949.

The National Institute of Nutrition

The National Institute of Nutrition, which is under the supervision of the Ministry of Welfare, was organized in the fall of 1947. On 8 June 1948, however, it was given new prominence by its establishment in a new building completely equipped with facilities for nutri-

tional research. The advisory board of the National Institute of Nutrition includes individuals trained and experienced in agriculture and food processing. A branch experimental station for various agriculture experiments related to nutrition is located in Chiba prefecture.

The Institute has now started experiments on timely nutritional projects and they are expected to contribute toward the solution of the many nutritional problems now confronting the nation.

The Japanese Nutritionists Association

This association was reorganized in May 1946 and its current membership of 2,800 members is restricted to licensed nutritionists. The association has as its main purpose the improvement of nutrition standards in Japan. The nutritionists' bill, passed by the Diet on 10 November 1947, requires nutritionists to be graduates of specialized schools of nutrition prior to licensing. This has aided the association by setting up nutrition education standards.

Nutrition Education

On 15 June 1948 the first nutrition refresher course was completed at the Institute of Public Health in Tokyo, from which 38 nutritionists representing various prefectures in Japan received certificates. This course was of two months' duration. Current plans provide the conducting of four such courses each year, each new class to begin the month following the conduction of the national nutrition surveys. This, therefore, will permit nutritionists from each of the prefectures to participate in these refresher courses.

Nutritionists are being employed in the various health centers throughout the nation and as a means of furthering nutritional education, a two weeks' nutrition refresher course is conducted in the model health center in Tokyo to acquaint these appointees with their duties prior to being given permanent assignments in one of the nation-wide health centers.

Future plans call for a continuance of current programs until the outside need of nutritional data in relation to food requirements, especially imported food, no longer exists. No changes are contemplated in the present procedures. Continued efforts will be made to educate the civilian population on the various methods of preparation of imported food to permit full utilization of their nutritional value.

Chapter 9

SUPPLY

Japan's Public Health Supply Situation Upon Surrender

The country had been devastated by war and aerial bombardment. Millions were homeless and without adequate clothing, living under deplorable conditions of environmental sanitation caused by widespread destruction. The resistance to disease had been lowered by malnutrition and food shortages, hospitals and other public health facilities had suffered extensive damage, and medical and sanitary supplies for protection against or treatment of diseases were unavailable. The morale of the people, dazed by surrender, unable to comprehend the future, had collapsed.

Before the war the pharmaceutical and allied industries of Japan had been developed to a degree which permitted an extensive export trade throughout the Orient. Emphasis had been rather on quantity than on quality. Surgical instruments, x-ray equipment and other hospital supplies and equipment had been produced in small factories. Due to war activities, these industries suffered severe physical losses. Approximately 50% of the factories engaged in the manufacture of medical supplies and equipment had been destroyed or had been converted to the production of war materials. Those able to function at the time of surrender could produce only 20% of pre-war requirements. Lack of raw materials and deterioration of equipment were responsible. At the beginning of the occupation, manufacturing activities were stagnant.

The government had established rigid controls over production. The Ministry of Welfare was responsible for the manufacture of pharmaceutical supplies and equipment, but had never been given sufficient control to carry out this responsibility. Other ministries controlled the allocation of raw materials and were not obligated to follow recommendations of the Ministry of Welfare concerning allocations to medical supply industries.

There was no comprehensive plan for production control. One of the outstanding operational deficiencies was the failure to determine actual requirements as a guide in the allocation of raw materials and in the formulation of production schedules.

The government purchased the bulk of the products of manufacturers for the armed forces. The civil population received a very small share. It was estimated that two-thirds of the medical supplies produced were taken by the Japanese Army and Navy. Although the government had set up rigid controls over production and distribution, the armed forces were allowed to fill their demands without regard to the needs of the civil population. This practice served to create chaos and to encourage hoarding and marketing through unauthorized channels.

Distribution as well as production was accomplished through a series of control associations and companies, each of which controlled a specific commodity group. These organizations were established in 1942 to integrate their respective industries with the war economy.

Public Health and Welfare in Japan

They operated on a commercial basis with the government assuming no financial responsibility for economic control. Although it was basic policy to delegate control to industries, the officials of control organizations were appointed by the government and operated under strict governmental supervision. Control associations purchased the products of manufacturers and conducted a wholesale operation through sales to corresponding control companies, one in each prefecture. This disrupted distribution through normal channels, creating severe bottlenecks. The quantities distributed had gradually diminished as the war progressed and were entirely inadequate during its later stages. No medical supplies had been distributed between June 1945 and the end of hostilities.

Physicians, dentists, veterinarians, sanitarians and hospital officials were unanimous in their opinion that extensive importation would be necessary to maintain a minimum standard of medical care and treatment. This opinion was shared by the general public. Severe criticism was expressed of policies regarding medical supplies for the civil population.

Initial Steps

Immediately after the arrival of the occupation forces, surveys were instituted, aimed at determining the medical supply situation. It was learned that potential capacities for production were available despite the extensive damage to pharmaceutical plants. Manufacturers were anxious to re-establish their production. The decision was made; (1) to attempt to rehabilitate the medical supply industries and stimulate indigenous production, rather than furnish needed supplies by an extensive and expensive import program, or (2) to supplement this production by import only of those materials, preferably in raw form, which would not be available in Japanese supply.

The Japanese Government was directed to provide the medical, dental, veterinarian and sanitation supplies and equipment required to maintain adequate standards of medical care and treatment. United States produced supplies were authorized for use only when Japanese resources were insufficient to prevent widespread disease and unrest in the civil population. The Ministry of Welfare was required to develop procedures to fulfill its supply responsibility. Ministry officials were given guidance and training to enable them to increase production and establish effective distribution.

Use of Japanese Military Stocks

At the time of surrender all supplies and equipment of the Japanese Army and Navy were confiscated by the Occupation Forces. Upon completion of inventory, non-war materials such as medical supplies, food and clothing, were returned to the Japanese Government for civilian use. These represented sizeable stocks of supplies which could meet emergency needs and were definite aids to supply problems encountered at the beginning of the Occupation.

Steps were taken to require the Japanese Government to distribute medical supplies to physicians, dentists, veterinarians, pharmacists

and hospitals. Execution of this distribution project was delayed because most of the supplies were stored in large depots and dumps, many in remote locations, which made inventory, classification and transportation difficult. Officials of the Ministry of Welfare and prefectural health and welfare agencies were organized to carry out this program.

Allocations of former military stocks of food and clothing for relief purposes were established by the Japanese Government. Stocks consisting of approximately 30,000 tons of canned meats, fish and biscuits, and three million pieces of clothing were included. The food was particularly useful in supplying hospitals and indigents during the food deficit period that occurred during the summer of 1946. (Ref. chart 30)

Import Programs

Import programs were instituted to furnish essential medicines and necessary raw materials to supplement indigenous supplies. These imports were calculated and programmed based on levels of essential items to provide minimum standards of health to prevent widespread disease and unrest. Progressively as the pharmaceutical and medical supply industries were rehabilitated it has been possible to reduce the quantities of finished medicines imported from a total of 40 medicines in the fiscal year 1946 to three in the budgetary estimate for fiscal year 1950.

In addition to regularly scheduled import programs, United States Army surplus medical supplies were made available to aid in the critical conditions of the early occupation period. These stocks proved of great value during this period of scarcity, until the indigenous industries could be re-vitalized for production (Ref. "Fiscal - U. S. Appropriated Funds", Chapter 9).

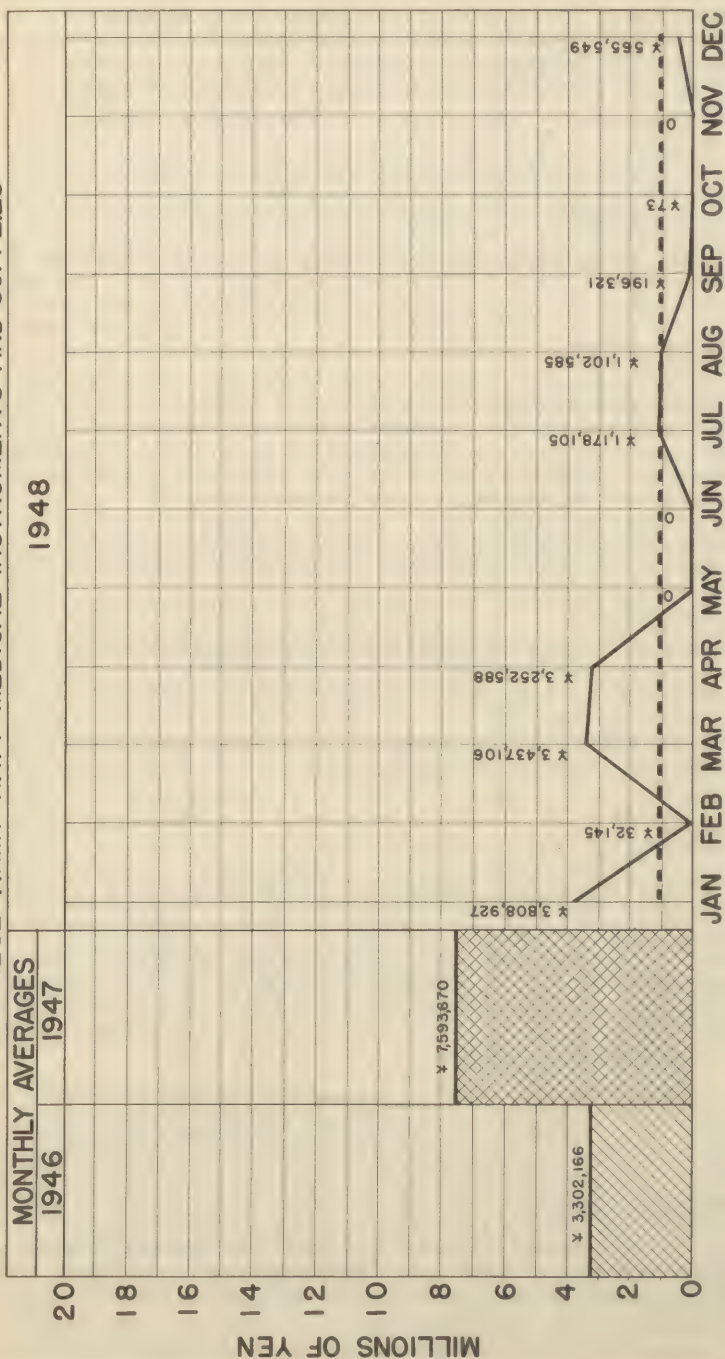
Production

An overall production plan was developed, together with a bill of materials necessary to accomplish this plan. Priority was assigned to the production of essential supplies to effect utilization of limited stocks of raw materials. In carrying out the basic production program it was necessary to place special emphasis on certain commodities. This was accomplished by the initiation of programs designed to insure priority of production for the most essential and critical items of medical supply and equipment.

Sweeping changes have been made in the system of production control and allocation of raw materials. The responsibilities of the Ministry of Welfare have been clearly defined and other Japanese agencies recognize the Ministry as the agency responsible for supply of medical and sanitary materials. With the establishment of the Economic Stabilization Board, responsibility for allocation of raw materials was removed from the various industrial groups that had maintained a monopoly. The Pharmaceutical and Supply Bureau of the Ministry of Welfare is the designated agency responsible for allocations to medical supply industries.

DISTRIBUTION

JAPANESE ARMY-NAVY MEDICAL INSTRUMENTS AND SUPPLIES



The Ministry of Welfare has kept step with the development of the Economic Stabilization Board, has assumed complete control of allocations made by the board, and makes definite allotments of these raw materials and intermediates to manufacturing plants. This is one of the most important developments in the production of medical supplies contributing to the rapid increases in production. (Ref. charts 31, 32, 33, 34, 35, 36).

Biologic Products

Although Japan had carried on a few disease immunization programs prior to the war, they were allowed gradually to lapse. At the time of surrender very few vaccines were being manufactured and distributed. The production of biologics was one of the first programs undertaken. Typhus vaccine and diphtheria toxoid production was introduced into Japan for the first time. During the first year of the occupation all types of essential production reached the minimum level required to carry out immunization programs. Import was necessary in the case of typhus vaccine only. A small reserve of miscellaneous imported vaccines, established as an emergency measure at the time of the occupation, was used to supplement Japanese production.

During the first few months of 1946 sufficient smallpox vaccine was produced to immunize the entire population of over 78,000,000. The production of all types of essential biologic products has reached a satisfactory level to make import of any type unnecessary. Standards and assay procedures have been developed and established to assure safe, potent and effective biologic products to carry out necessary public health measures. (Ref. charts 37, 38, 39, 40, 41, 42).

BCG vaccine widely used in Japan presented difficulties of storage and distribution. The wet type which has a short effective life of approximately six to seven days is being supplanted by the dry or lyophilized type which allows for production in a minimum of laboratories, and for ease of storage and handling.

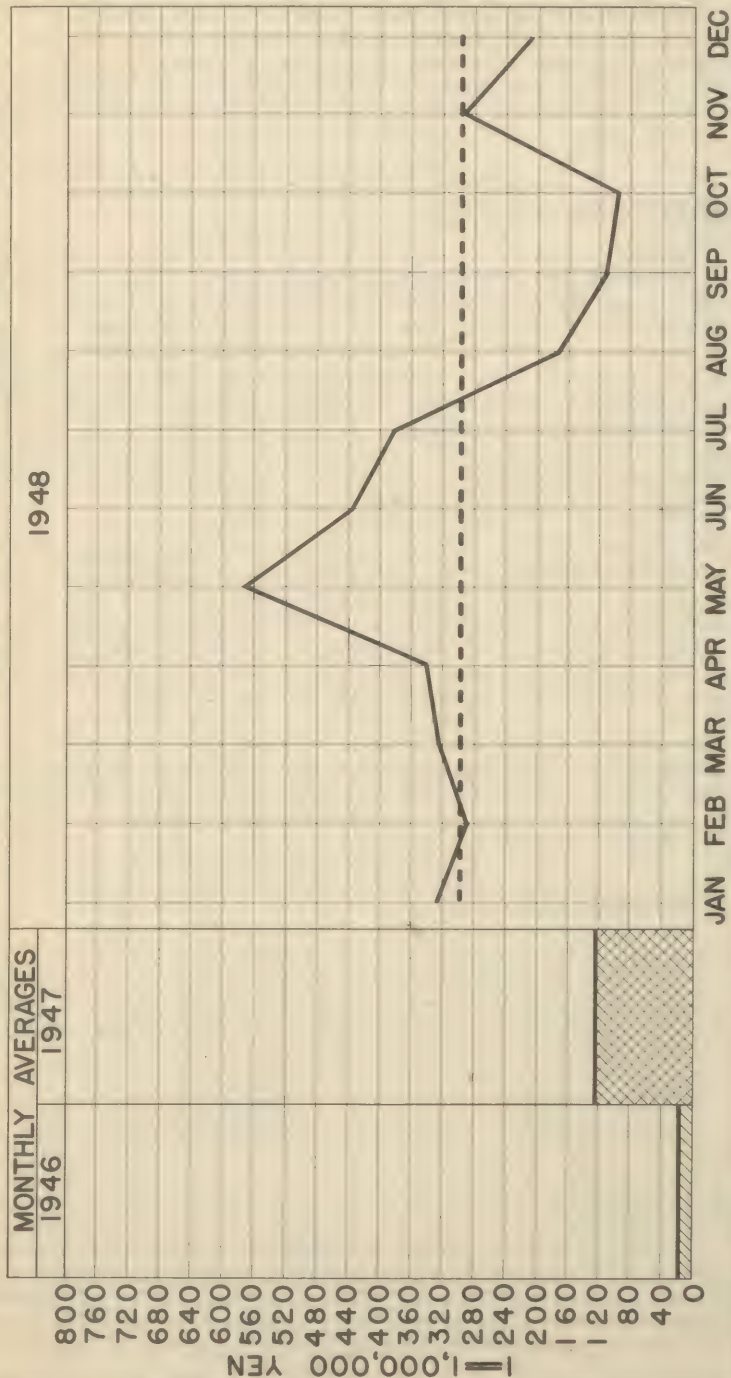
Approximate annual requirements for major biologic products are calculated as follows:

Diphtheria toxoid	8,600 liters
Typhoid-paratyphoid vaccine	65,381 liters
Pertussis vaccine	10,175 liters
Smallpox vaccine	60 liters (6,000,000 doses)
BCG vaccine	2,920 liters
Typhus vaccine	4,000 liters
Influenza vaccine	100 liters
Cholera vaccine	800 liters

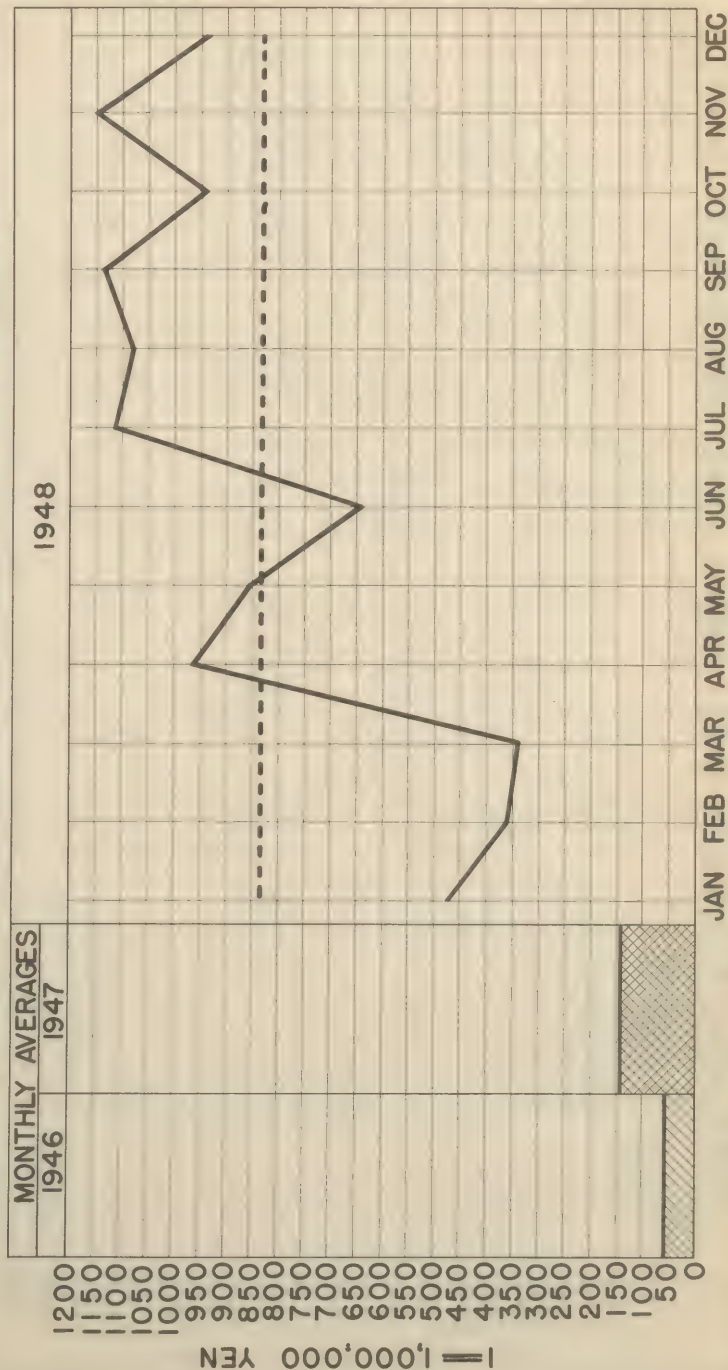
Laboratory Animals

A program for accelerating production of laboratory animals was necessary to accomplish assay on increased output of biologic products. The requirement was further increased by establishment of higher standards for principal biologic products. A Japanese committee was organized to participate actively in resolving this problem. Additional

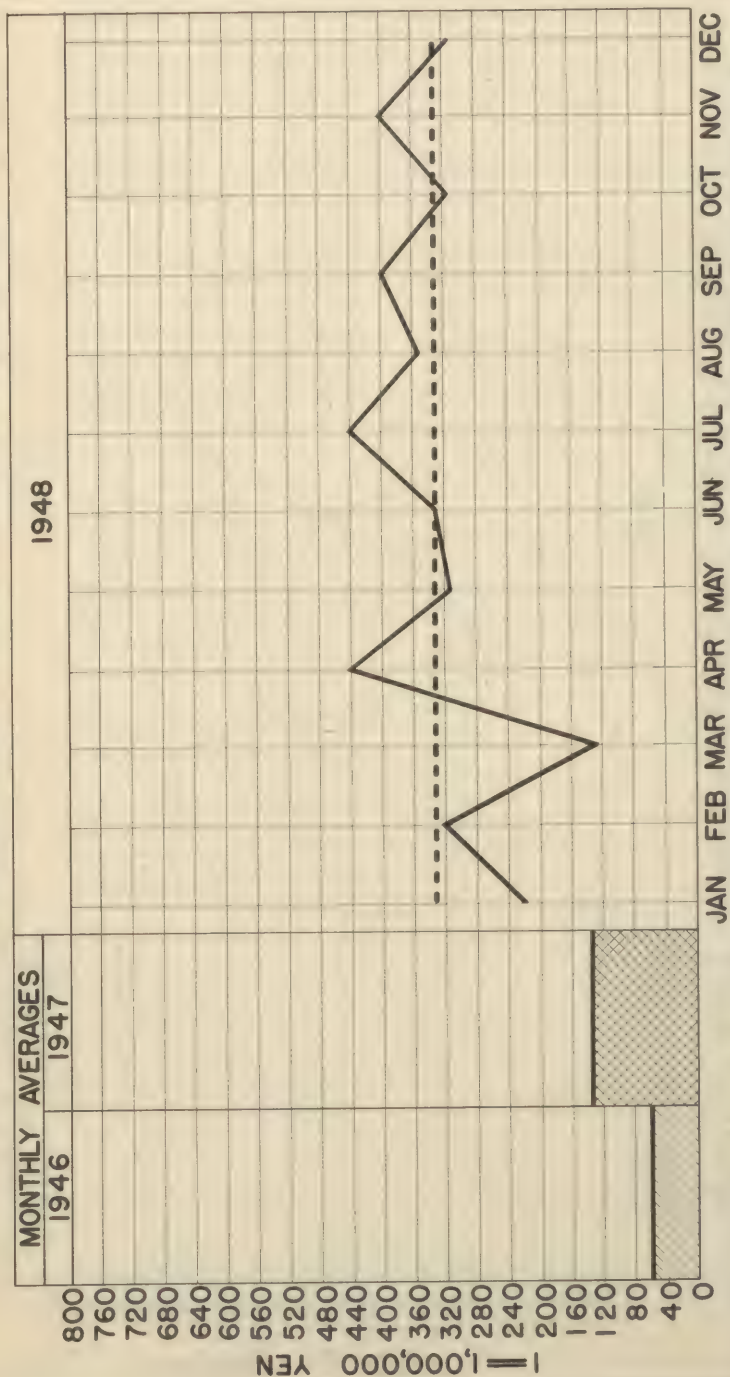
PRODUCTION CONTROLLED MEDICINES



PRODUCTION NON-CONTROLLED MEDICINES



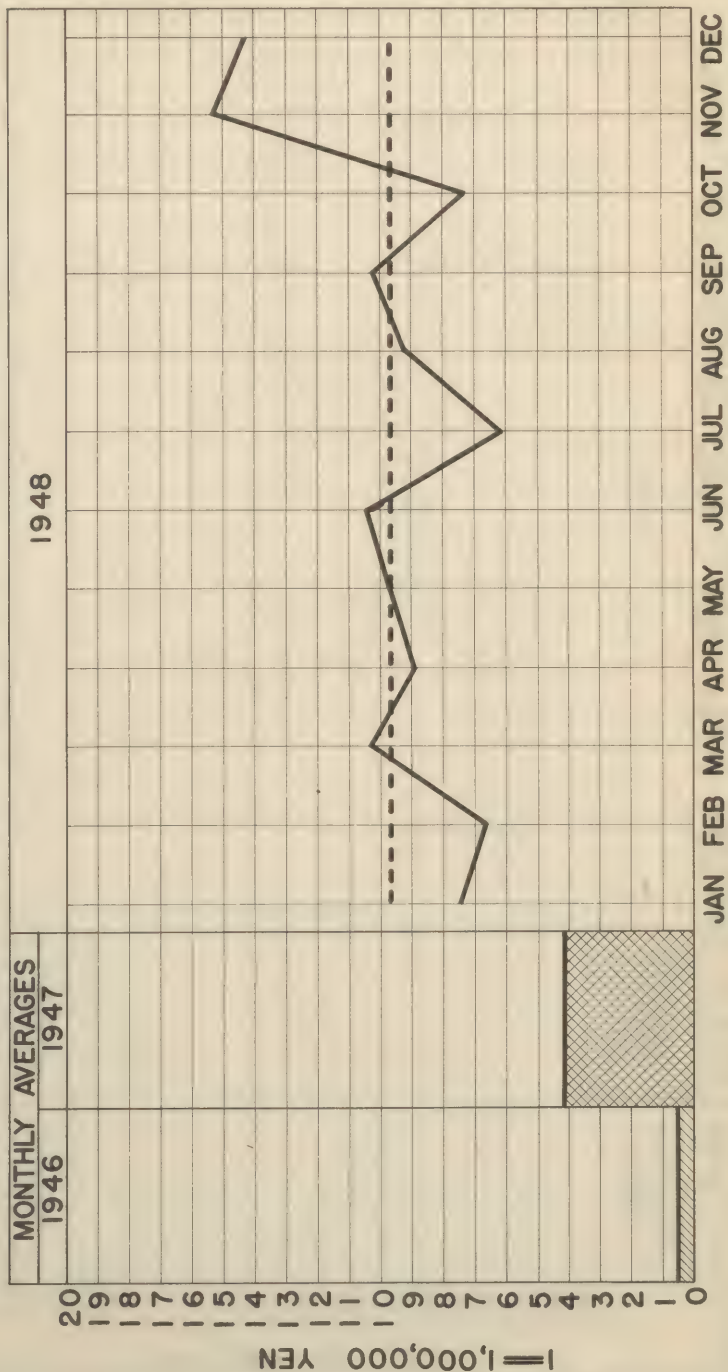
PRODUCTION PATENT MEDICINES



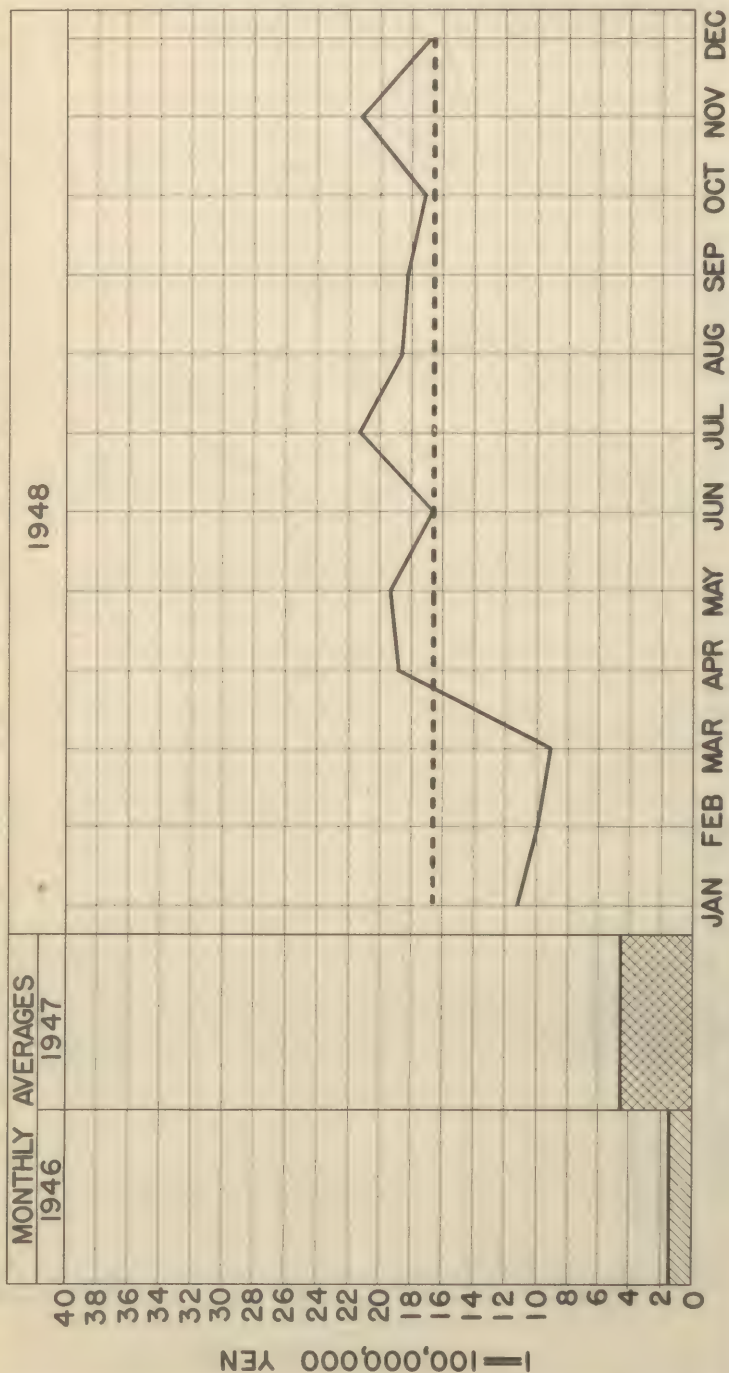
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PRODUCTION PATENT MEDICINES

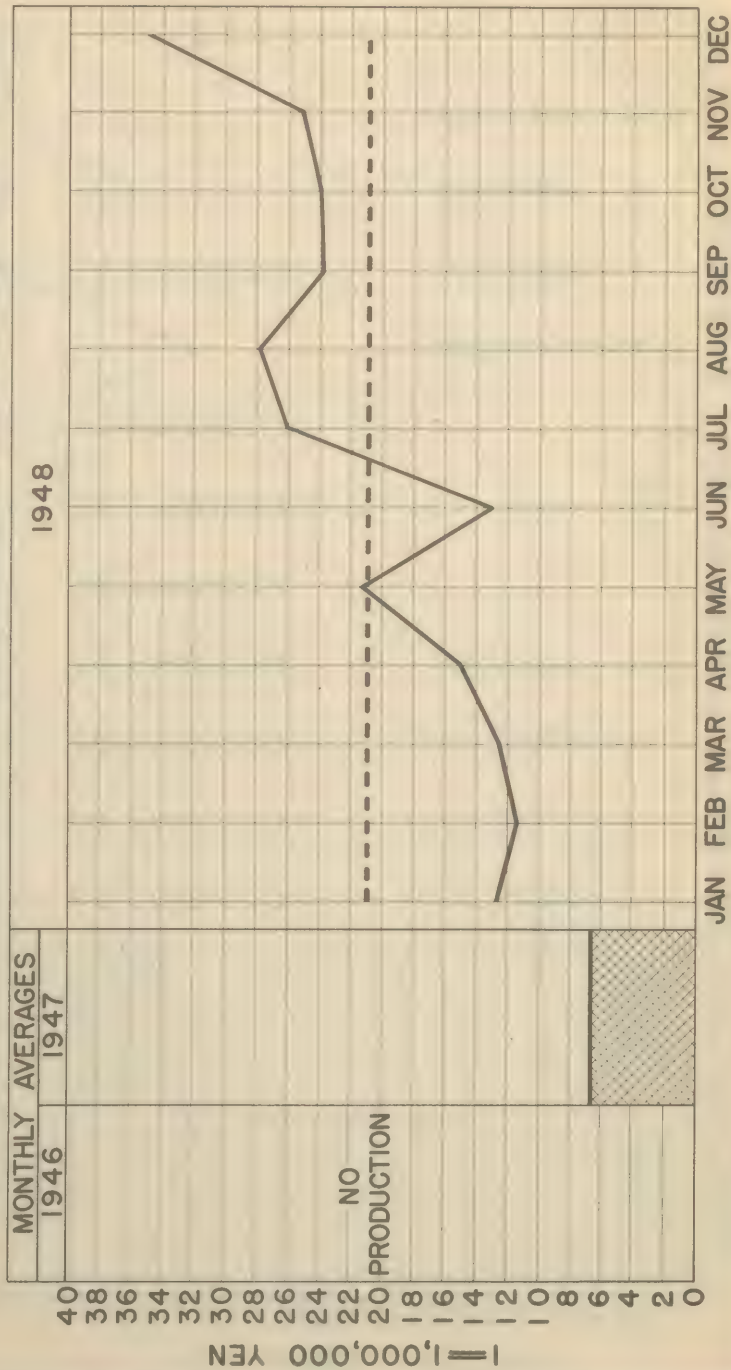
PRODUCTION DENTAL MATERIALS



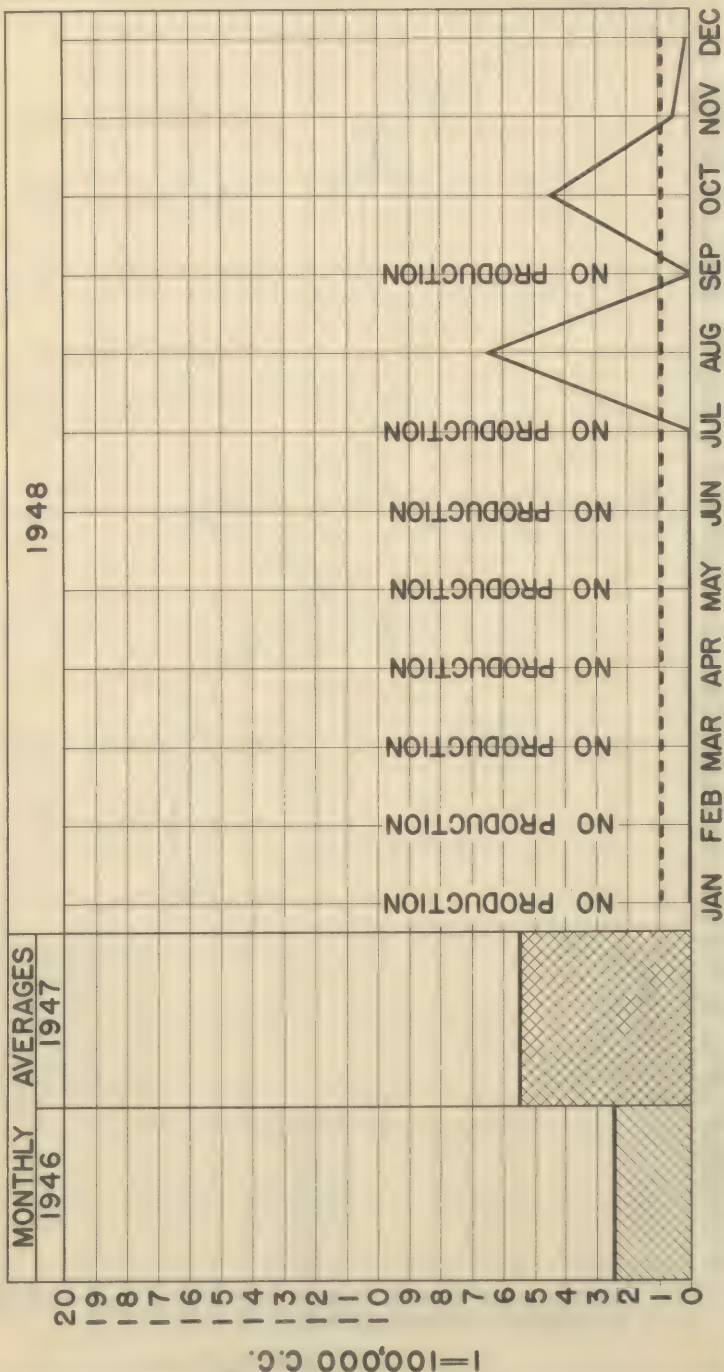
PRODUCTION MEDICAL SUPPLIES & EQUIPMENT



PRODUCTION RUBBER SANITARY GOODS



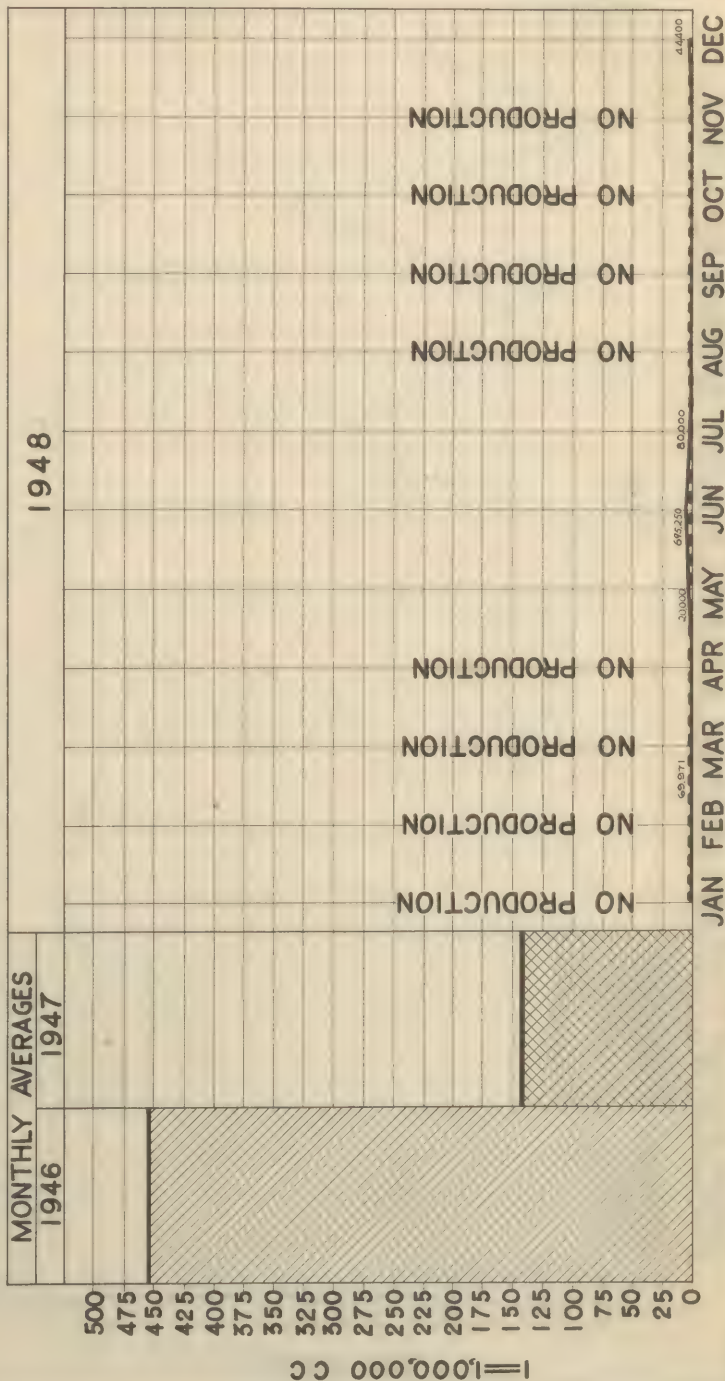
PRODUCTION BIOLOGICALS-TYPHUS



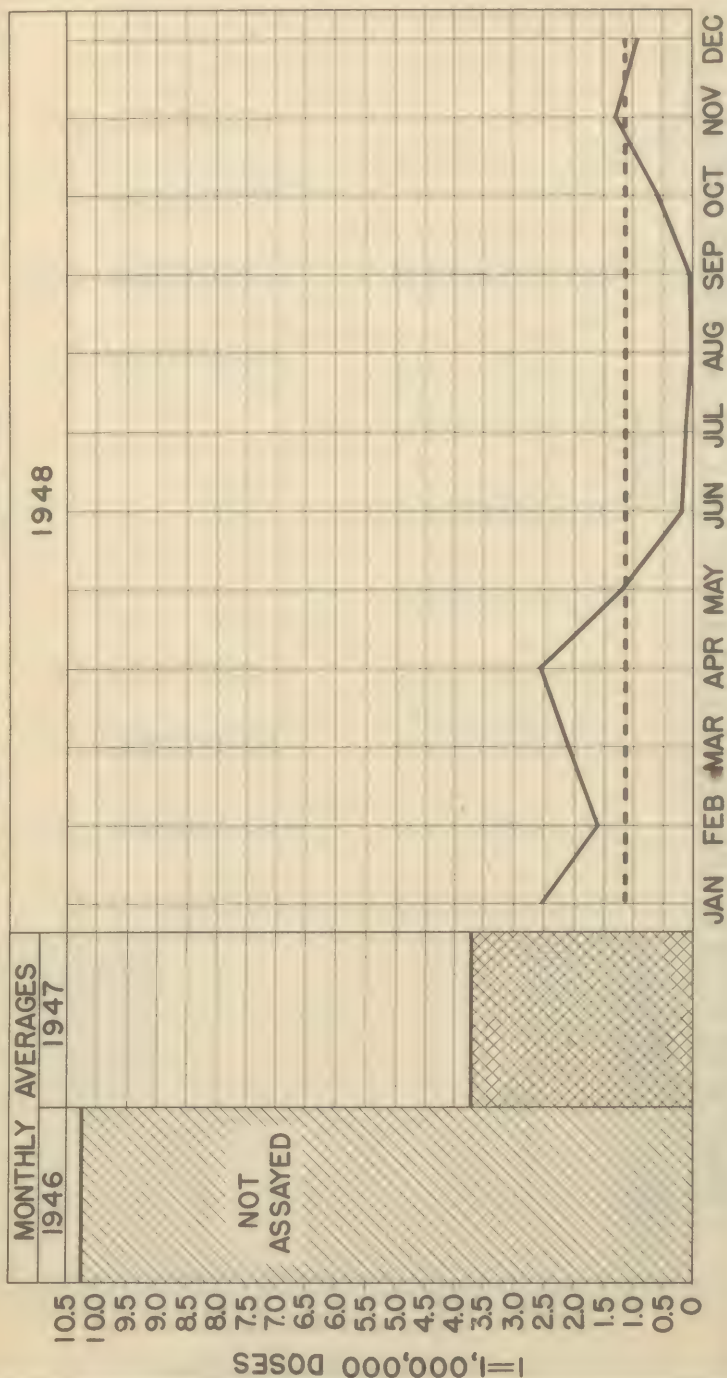
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PRODUCTION BIOLOGICALS CHOLERA

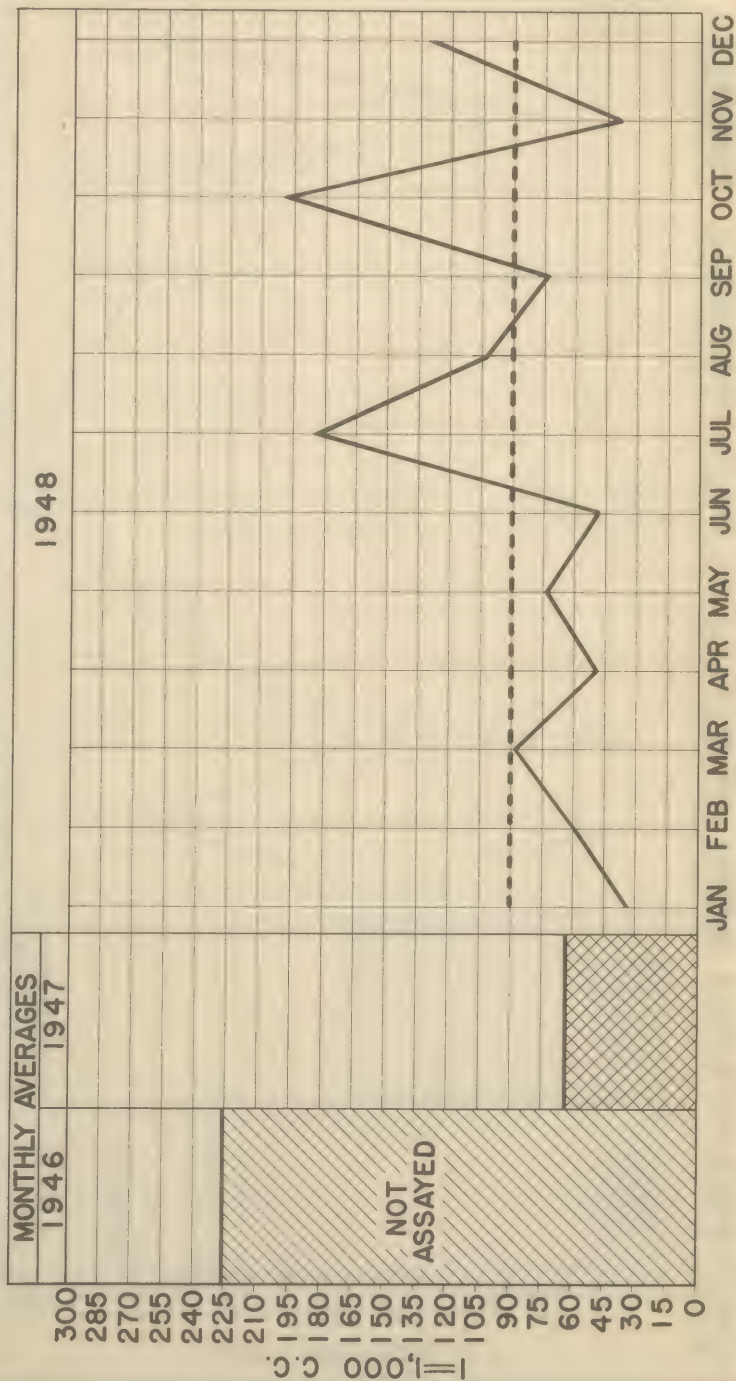


PRODUCTION BIOLOGICALS-SMALL POX

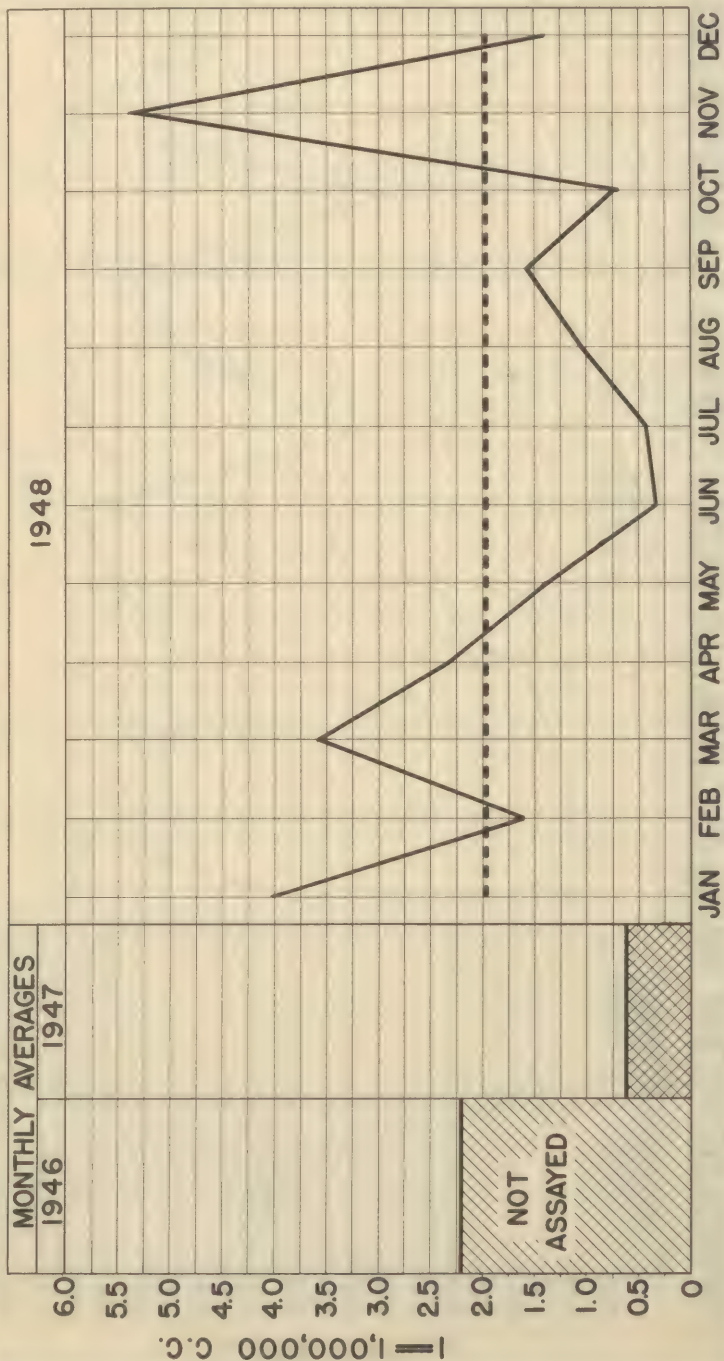


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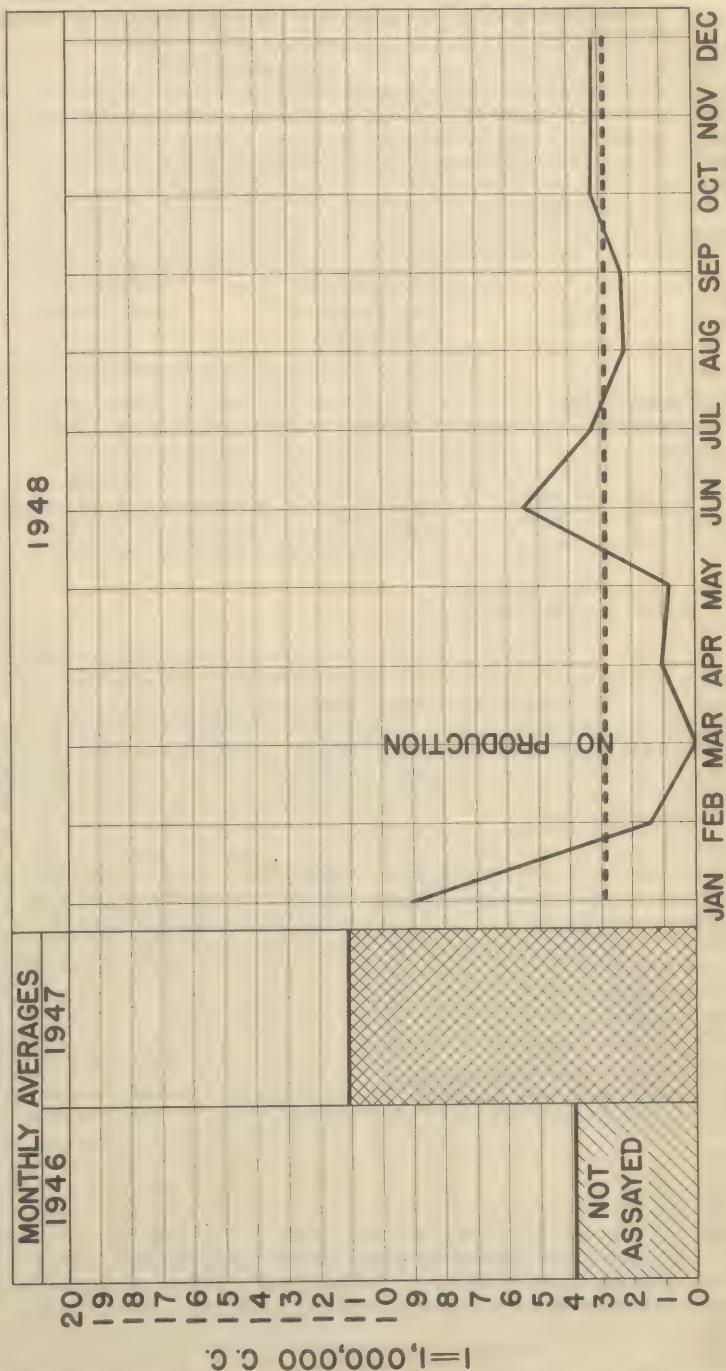
PRODUCTION BIOLOGICALS-DIPHThERIA ANTITOXIN



PRODUCTION BIOLOGICALS-DIPHTHERIA TOXOID



PRODUCTION BIOLOGICALS TRIPLE TYPHOID



Public Health and Welfare in Japan

animal feed allocations and materials for construction of cages were obtained. This action, together with widespread publicity encouraging farmers to increase production, gained excellent results.

The disastrous flood following the typhoon in September 1947 destroyed the entire animal population of the principal collection center. However, renewed efforts to again resume production on the scale formerly attained resulted in continued increases.

Annual requirements for laboratory animals are estimated as tabulated below:

	For National Assay Purposes at National <u>Institute of Health</u>	Research and Manufacturers' Needs
Guinea Pigs	65,553	150,000
Rabbits	13,670	30,000
Mice	299,197	550,000
Rats	-	12,000
Totals	378,420	742,000

Introduction of New Medicines

In order to introduce modern practices of disease treatment to post-war Japan, many drugs were introduced into the country for the first time. Initially these were brought in by import. At the same time production programs were initiated to enable industrial capacity in Japan to supply these valuable modern remedies from indigenous manufacture, resulting in a two-fold advantage: (1) rehabilitation of the Japanese economy and (2) reduction of import costs and costs of the occupation.

Such medicines as penicillin, sulfathiazole and sulfadiazine were introduced on a commercial scale. The modern venereal disease treatment drugs, mapharsen and bismuth subsalicylate, were placed in production. Manufacture of hexylresorcinol for treatment of the intestinal parasite infestations was started to supply a safe anthelmintic drug, and to satisfy the critical need for such medicines. Promin for treatment of leprosy is now made in Japan and sufficient capacity exists to satisfy all requirements. Streptomycin production is in the process of introduction. Import of all of these medicines, with the exception of streptomycin, has been discontinued because indigenous production is able to satisfy the Japanese requirements.

Penicillin

Penicillin had not been manufactured in Japan prior to the occupation, although some laboratory research was in progress. The Japanese were anxious to produce penicillin. Manufacturing, primarily on a laboratory scale, was instituted during the early part of 1946.

During the latter part of 1946 a penicillin consultant was temporarily assigned for the purpose of instituting a comprehensive production

program. Conversion from the surface production to the submerged method was accomplished under his direction. Progressively the conversion became complete until all production of any consequence is carried out by the submerged method. This permitted rapidly increasing production figures, until it was found possible and advisable to remove the distribution controls from this valuable antibiotic.

Progress has been phenomenal. In 1946 a total of the equivalent of only 23 vials of 100,000 oxford units each was produced. Continued increase in production has made it possible to remove distribution controls initially necessary. Rigid production standards are in effect. Assay is carried out by the National Institute of Health (Ref. chart 43).

Venereal Disease Control Drugs

Production of drugs for the treatment of the venereal diseases in Japan had not kept pace with modern medical practice. With the institution of up-to-date venereal disease treatment procedures it became necessary to produce a number of items not formerly manufactured in Japan. Emphasis was placed on the production of sulfathiazol, bismuth subsalicylate, and mapharsen. The production of all three of these important medicines has reached proportions to more than satisfy minimum needs.

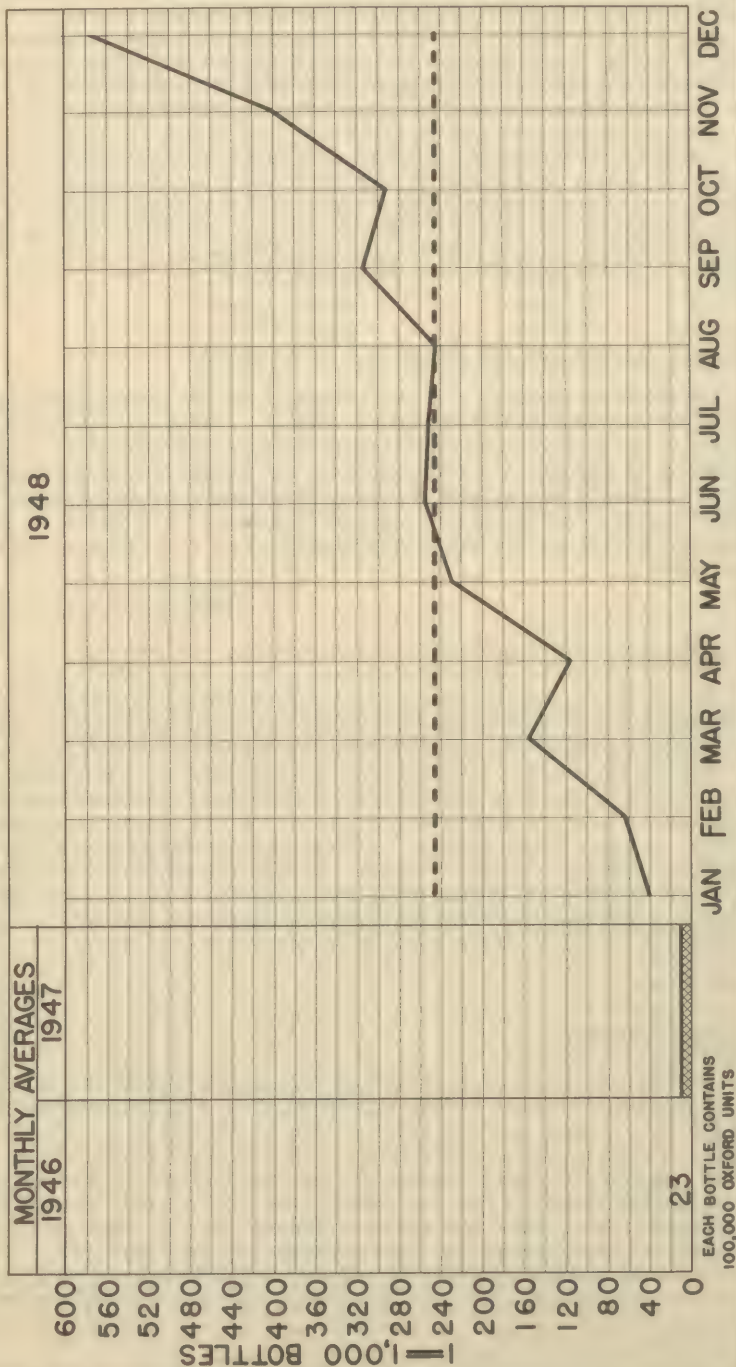
Sulfa Drugs

The Japanese pharmaceutical industry had produced sulfa drugs prior to the arrival of the occupation forces. However, the amounts were not substantial and the quality was questionable. A large portion of the product had been utilized in the manufacture of patent medicines. Sulfathiazol production was originally initiated with venereal disease treatment in mind, however, ample quantities are now being produced to meet all medical requirements. Sulfadiazine production was introduced with satisfactory results. With the possible exception of sulfadiazine, all sulfa drugs are supplied from indigenous production in ample quantities. Sulfadiazine, although no longer imported, is not yet sufficiently plentiful to satisfy all needs.

Surgical Dressings

At the cessation of hostilities only small stocks of surgical dressings and absorbent cotton were available. It was necessary for hospitals to rewash and sterilize soiled bandages and to use improvised materials such as paper dressings. With the development of the cotton import program for Japan immediate steps were taken to make available raw materials required for the manufacture of surgical dressings and absorbent cotton. From the amount allocated to the Japanese Government for domestic use quantities of raw cotton were made available for the production of cotton sanitary materials. Although the quantities so allocated have proved far from adequate, vast improvement has been experienced in the supply of absorbent cotton and surgical dressings (Ref. charts 44, 45, 46, 47).

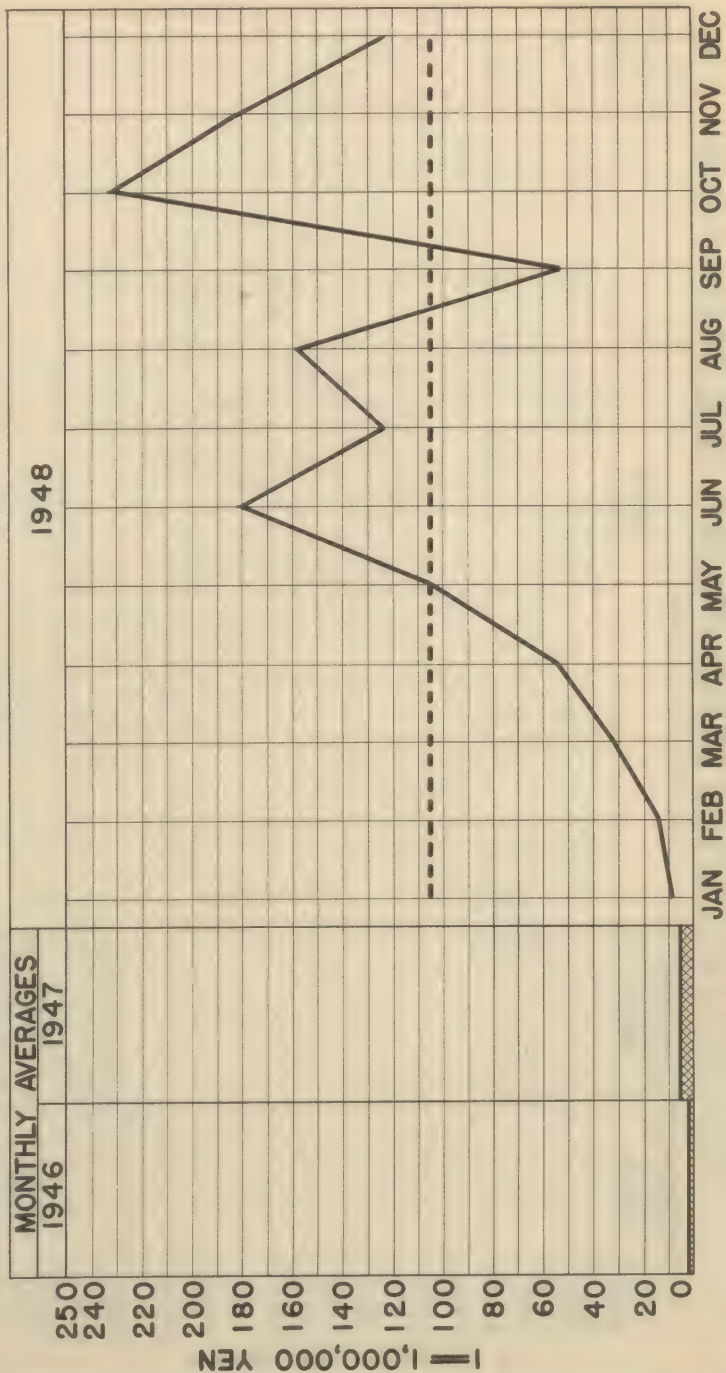
PRODUCTION PENICILLIN



(43)

PHARMAS CHART NO 2-19 28-3 1946

PRODUCTION SANITARY MATERIALS



(44)

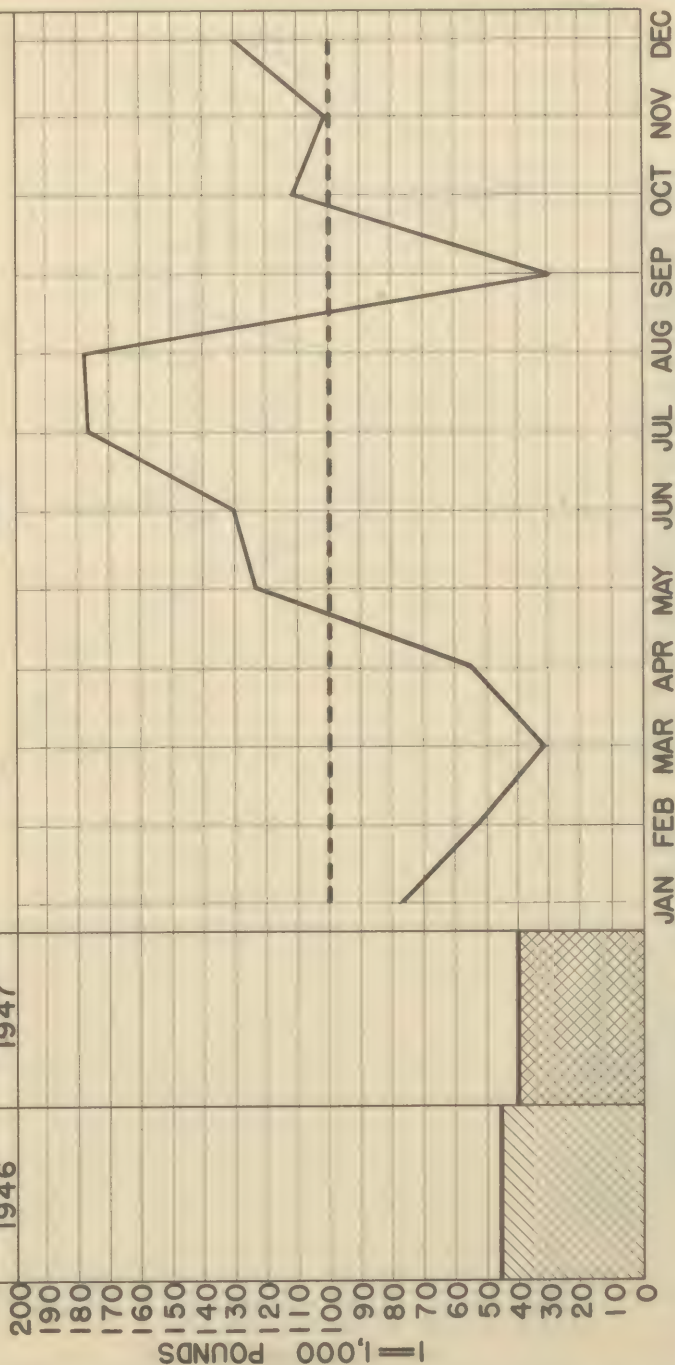
PH&WHS CHART NO. 320 29-3-1949

BANDAGE CLOTH

MONTHLY AVERAGES

1946	1947
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1948

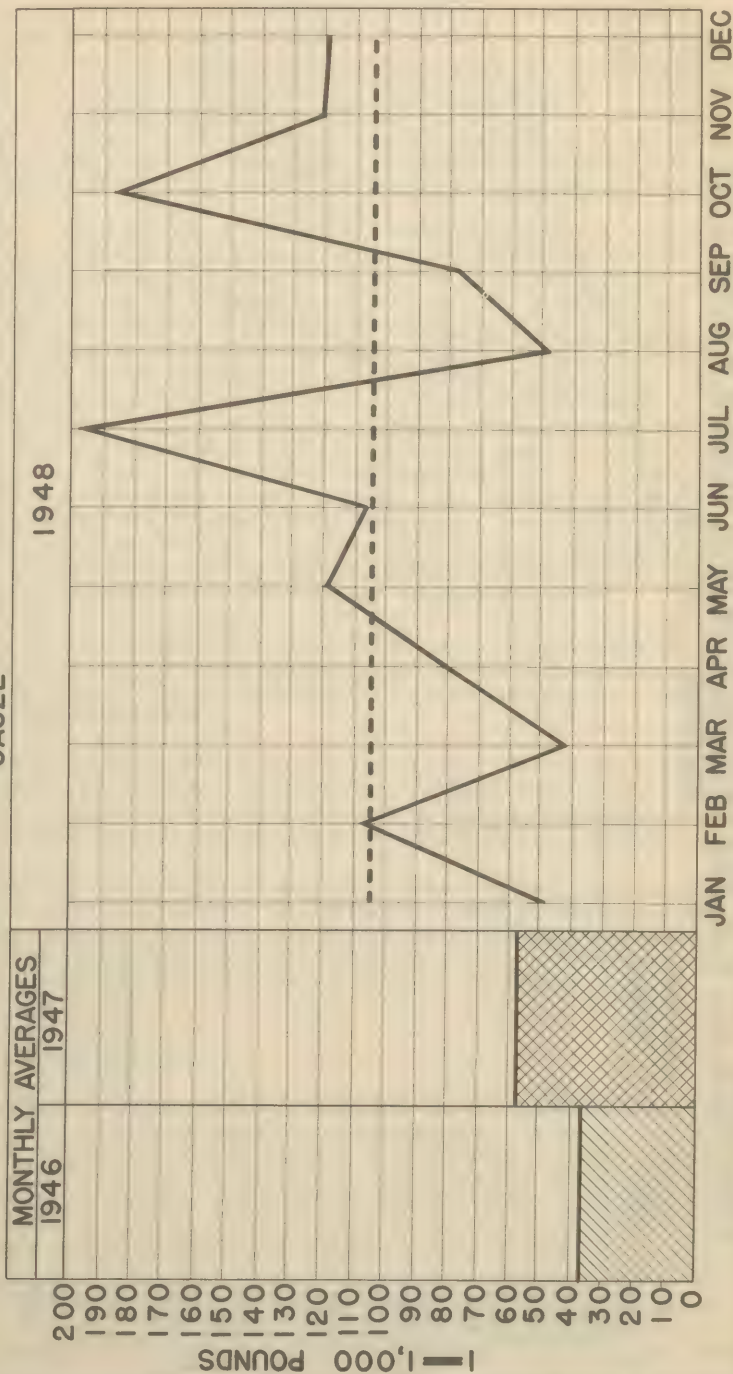


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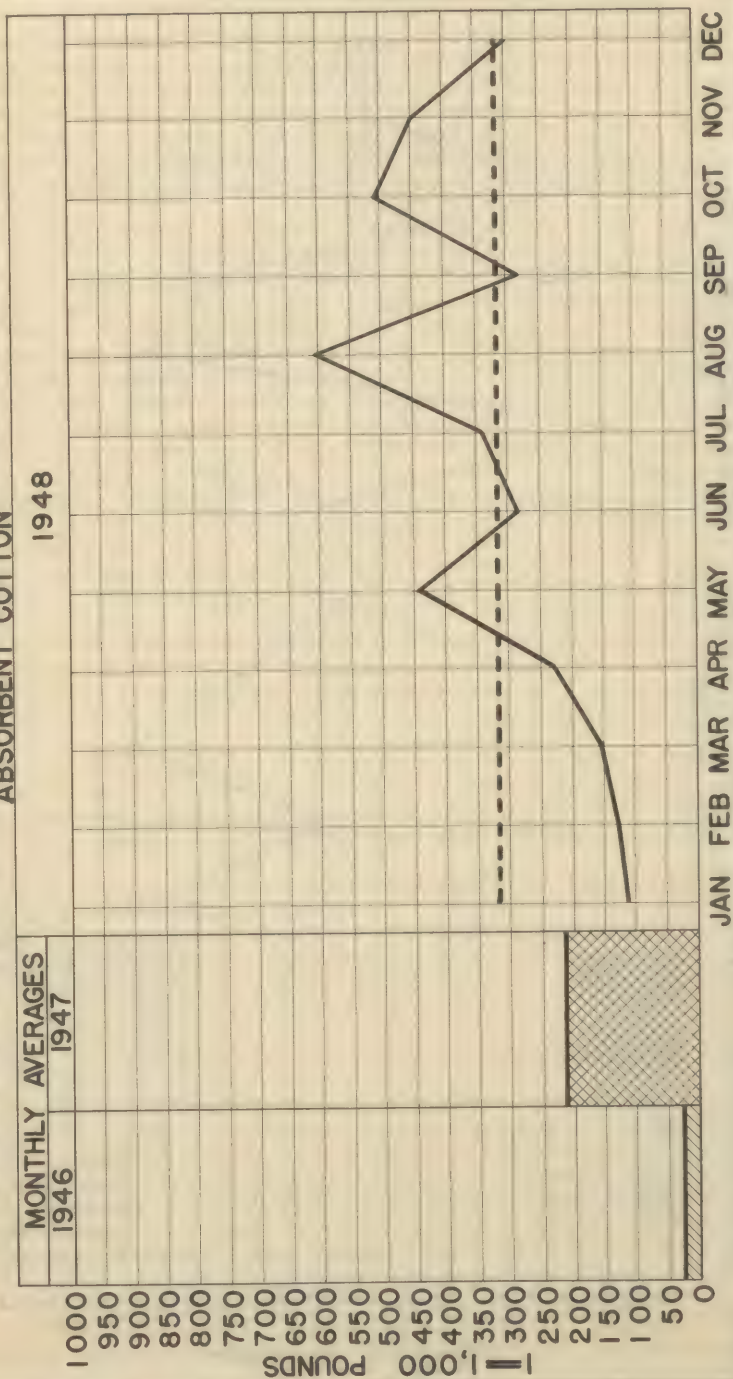
PHYSICALS CHART NO J-9 10-7-1948

PRODUCTION SANITARY MATERIALS

GAUZE



PRODUCTION SANITARY MATERIALS ABSORBENT COTTON



(47) PHAW/HIS CHART NO. J-11 8-7-48

Insect and Rodent Control Supplies and Equipment

During the early part of 1946 a comprehensive insect and rodent control program was instituted throughout Japan. Large quantities of supplies and equipment were required for this program and action was instituted to utilize indigenous production facilities to the greatest possible extent. This program required the production of pyrethrum emulsion, phenothiazine, other types of miscellaneous insecticides, and the necessary equipment required for spraying and disinfection.

Since Japan is one of the world's largest sources of pyrethrum flower it was possible to produce large quantities of effective insecticides. It was found necessary to import DDT products required for the public health programs because Japan was not able to produce DDT in sufficient quantity due to shortage of the raw materials necessary for the manufacture of the 100% DDT powder. However, local facilities were developed for mixing dusting powder, utilizing indigenous deposits of talc and other available materials. Petroleum products required for mixing the spray were furnished on an import basis. Since dusting powder consists of 90% diluent (talc), substantial savings in shipping space and costs were effected by local manufacture, as well as greater flexibility in supplying immediate needs. All logistic responsibility for DDT products was carried by the occupation forces until 1 March 1947. Since that time the Japanese Government has utilized imported 100% DDT and indigenous facilities for mixing 10% dust and 5% residual effect spray, and has handled all distribution throughout Japan.

A program of manufacture of 100% DDT in Japan was initiated and raw materials, fuel and power, were allocated for this purpose. The production of 100% DDT has progressed so satisfactorily that imports are no longer necessary.

During the early phases of the insect and rodent control program it was necessary to supply United States produced dusting and spraying equipment. However, Japanese production of this equipment was begun and importation was no longer necessary after the initial stage.

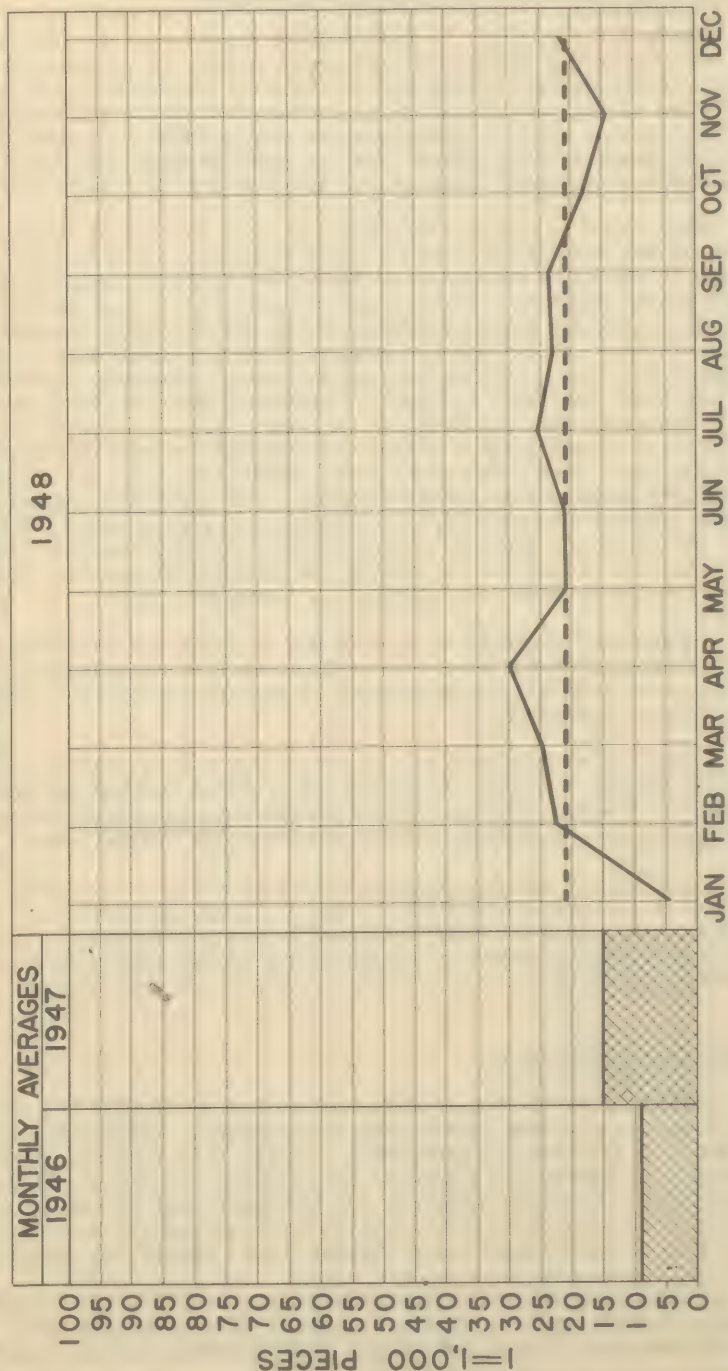
Production of rat poison was accelerated and kept pace with the progress of the rat extermination program. Large quantities of rat traps also have been produced and distributed. Production is now sufficient for the requirements of the extensive rodent control program that is being carried on (Ref. Charts 48, 49, 50, 51, 52, 53, 54).

X-ray Film and Equipment

During the early stages of the occupation x-ray film and the necessary chemicals for development were non-existent. Aggressive action was taken to increase the production of x-ray film to fixed established levels. This production quota has been met and has proven adequate to meet demands. Chemicals required for developing and processing the film also are available. Any hospital in Japan may purchase sufficient x-ray film to meet requirements through normal commercial channels.

A separate quota was set to provide materials for the anti-tuberculosis program. This program provides for chest examinations of a large percentage of the population. To supplement existing equipment

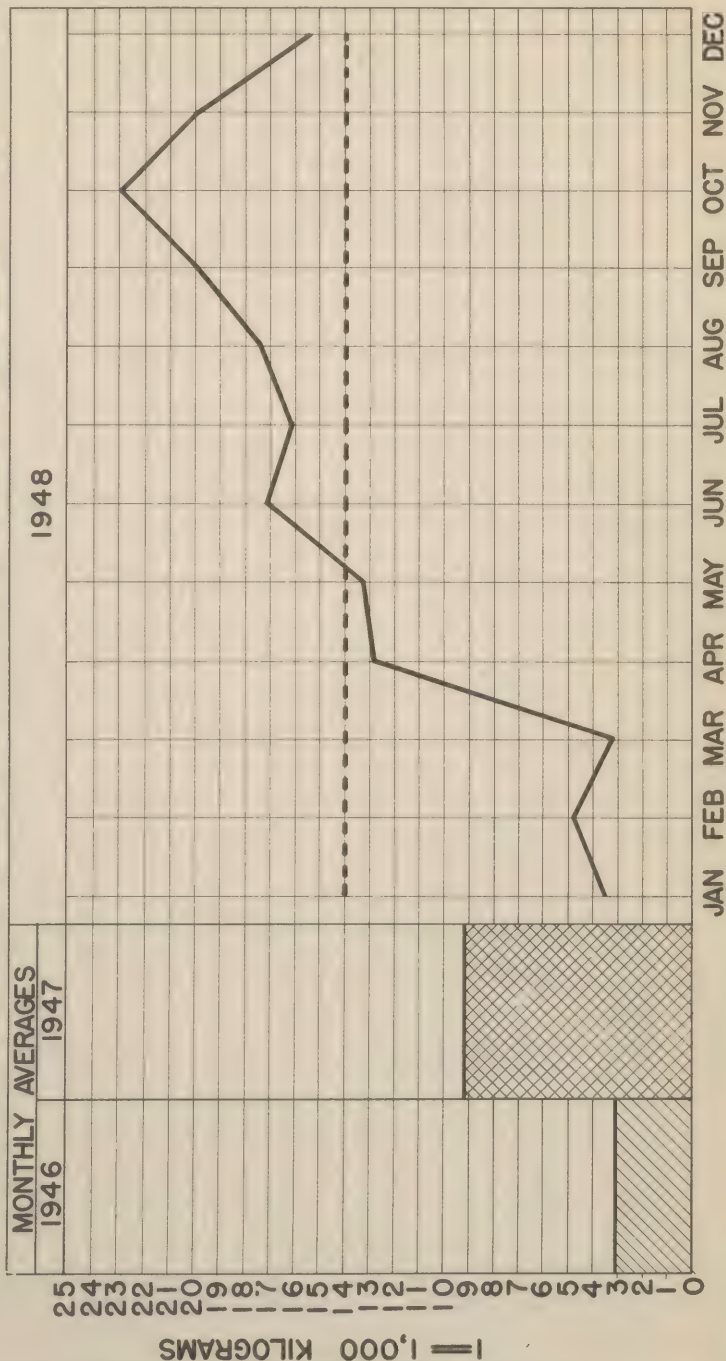
PRODUCTION OF SPRAYING AND DUSTING EQUIPMENT



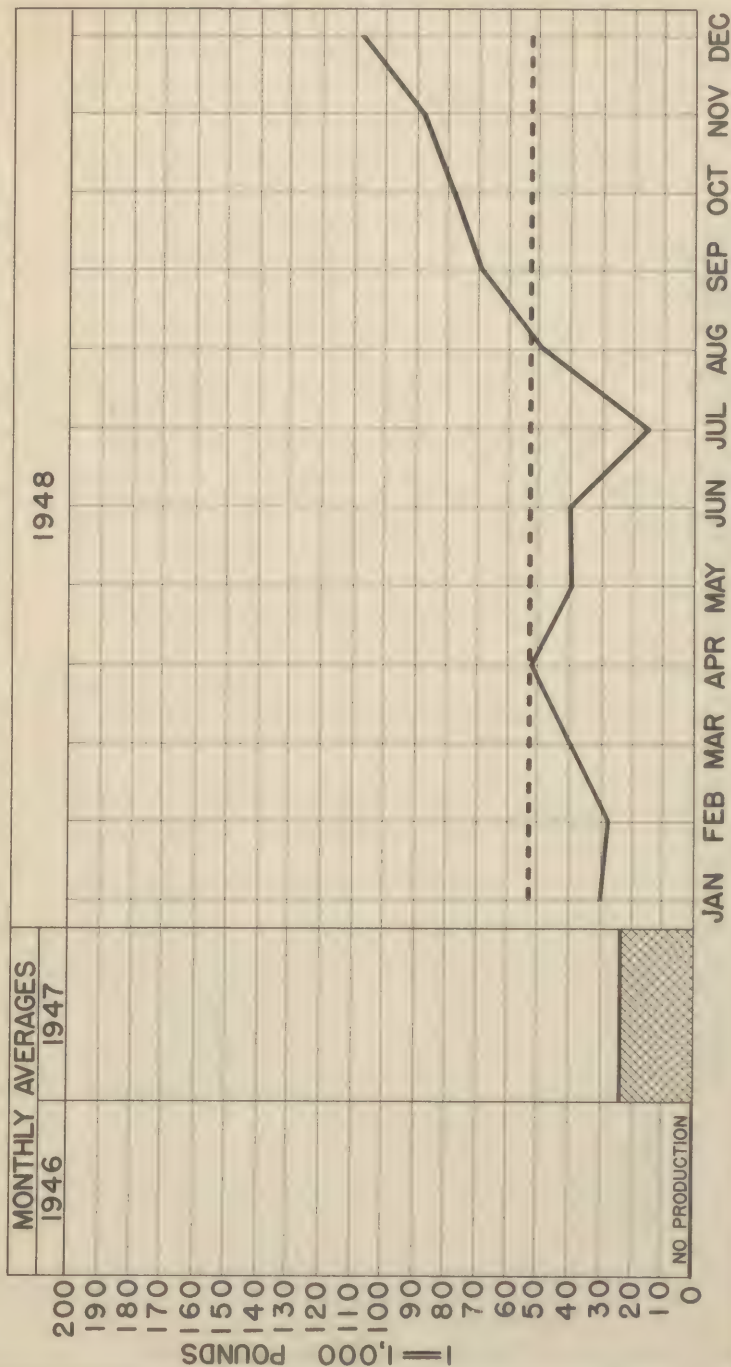
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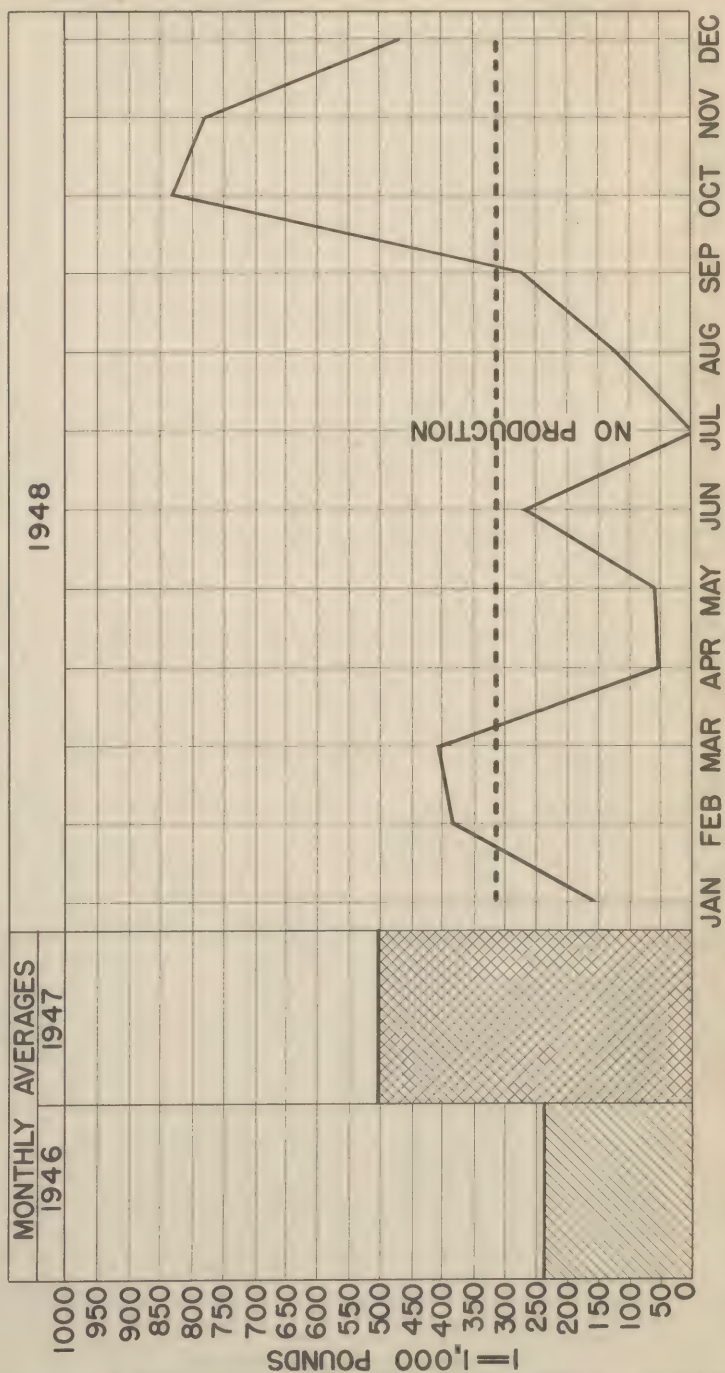
PRODUCTION RODENTICIDES



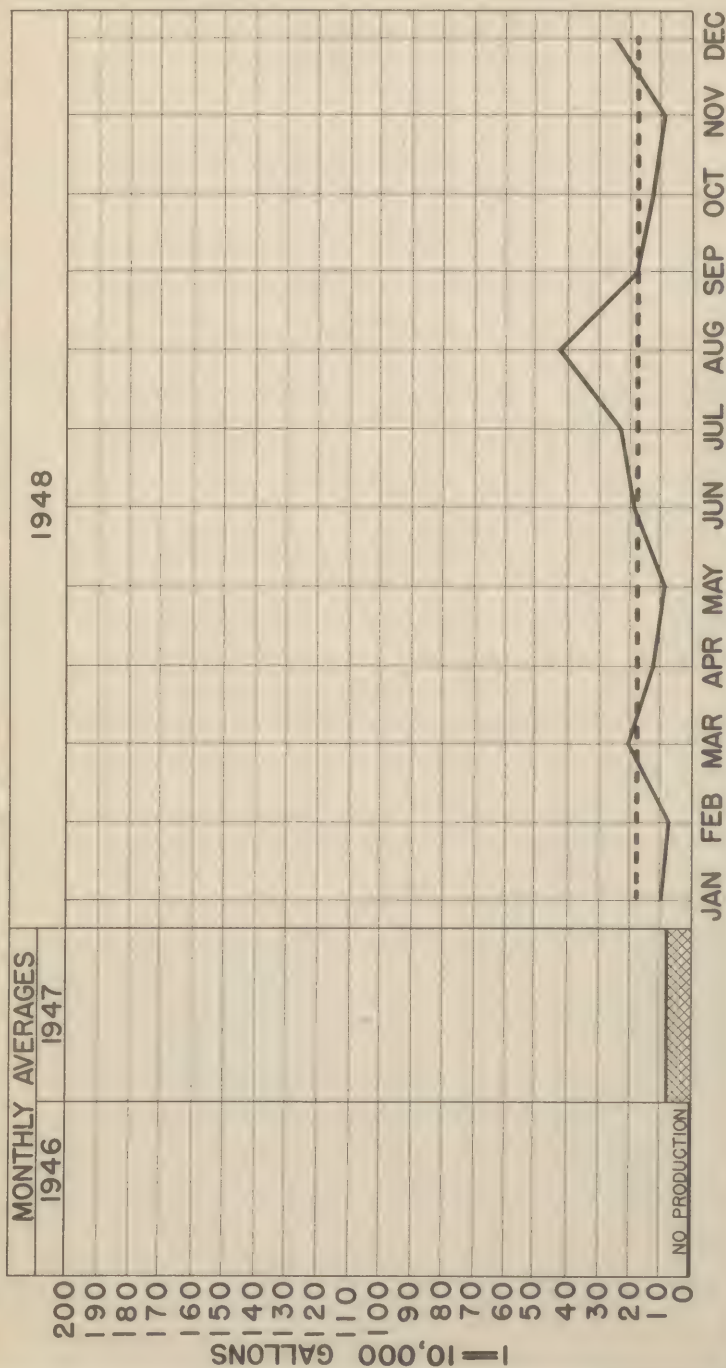
PRODUCTION DDT CONCENTRATE



PRODUCTION 10% DDT DUST

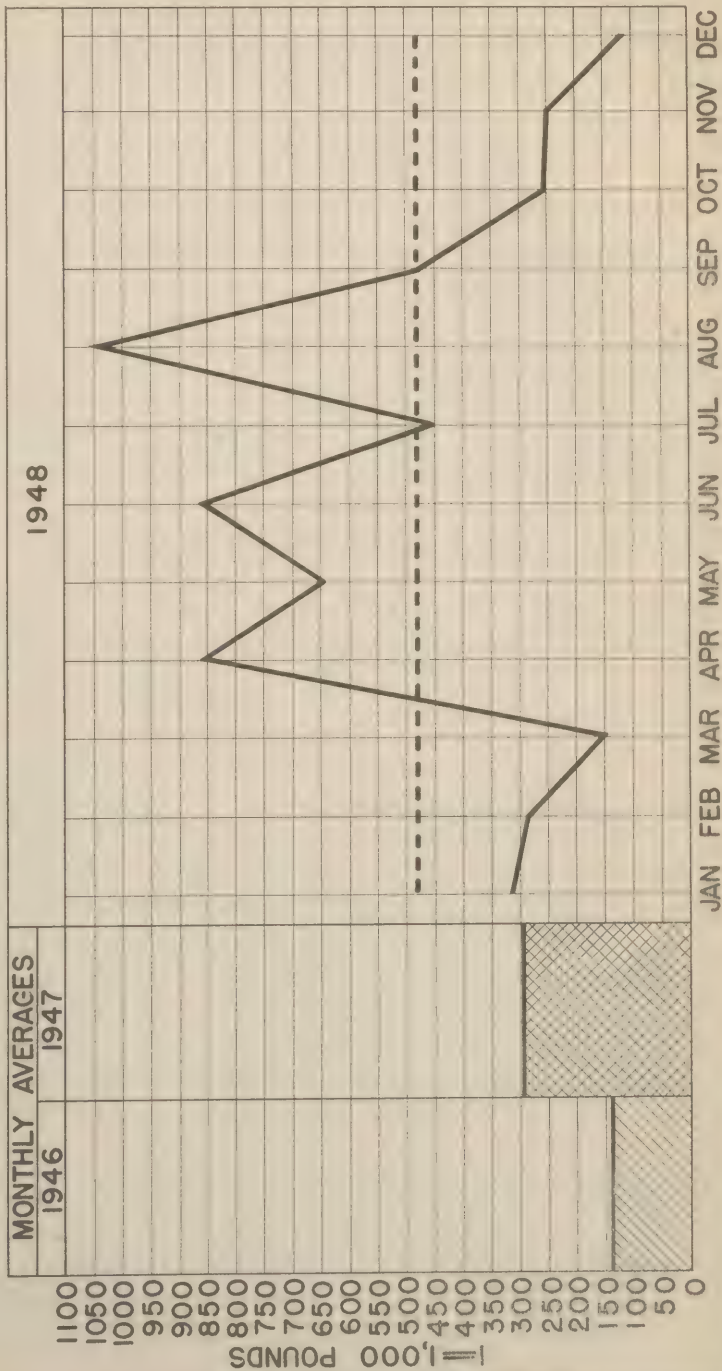


PRODUCTION 5 % DDT RESIDUAL EFFECT SPRAY



(52) PH&W/HS CHART NO 2-7 28-3-1949

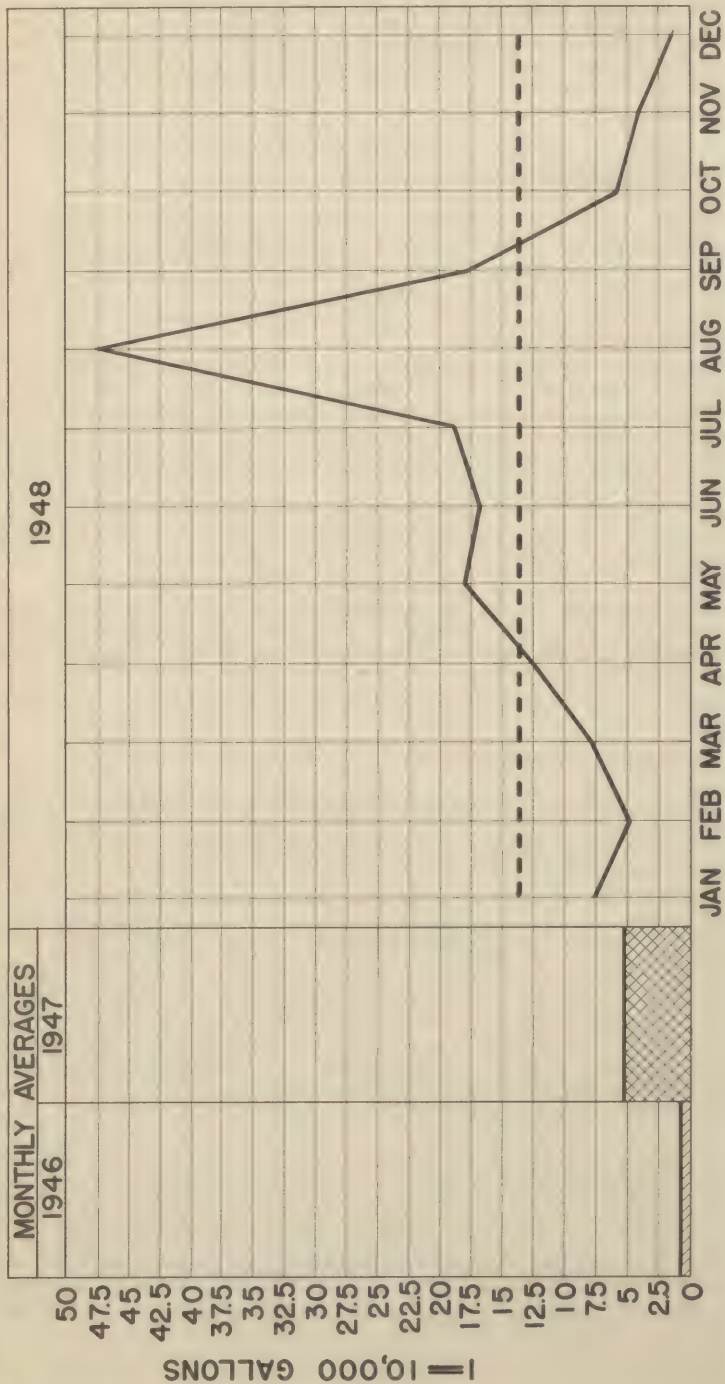
DISTRIBUTION 10% DDT DUST



PHAW/HS CHART No. J-32 22-5-5049

(53)

DISTRIBUTION 5 % DDT RESIDUAL EFFECT SPRAY



100 new photorcentographic machines were produced in early 1947.

Other x-ray machines and equipment are produced in sufficient quantities to meet requirements. The production schedule of both x-ray film and machines is maintained and no difficulties are being experienced (Ref. chart 55).

Instruments and Equipment

Before the war the Japanese medical, dental and veterinary professions relied primarily on instruments and equipment of foreign make. With the denial of this foreign source of supply during the war, the indigenous industry developed rapidly, copying foreign design. The quality of equipment, however, left much to be desired.

A great percentage of the factories manufacturing medical and surgical instruments had been converted to war material production. In addition, these factories suffered extensive war damage. With the cessation of hostilities, rehabilitation and reconversion to peaceful pursuits proceeded as rapidly as materials became available.

The industry has made a detailed study of its present production. Efforts are being made to standardize the production of all equipment and to improve quality.

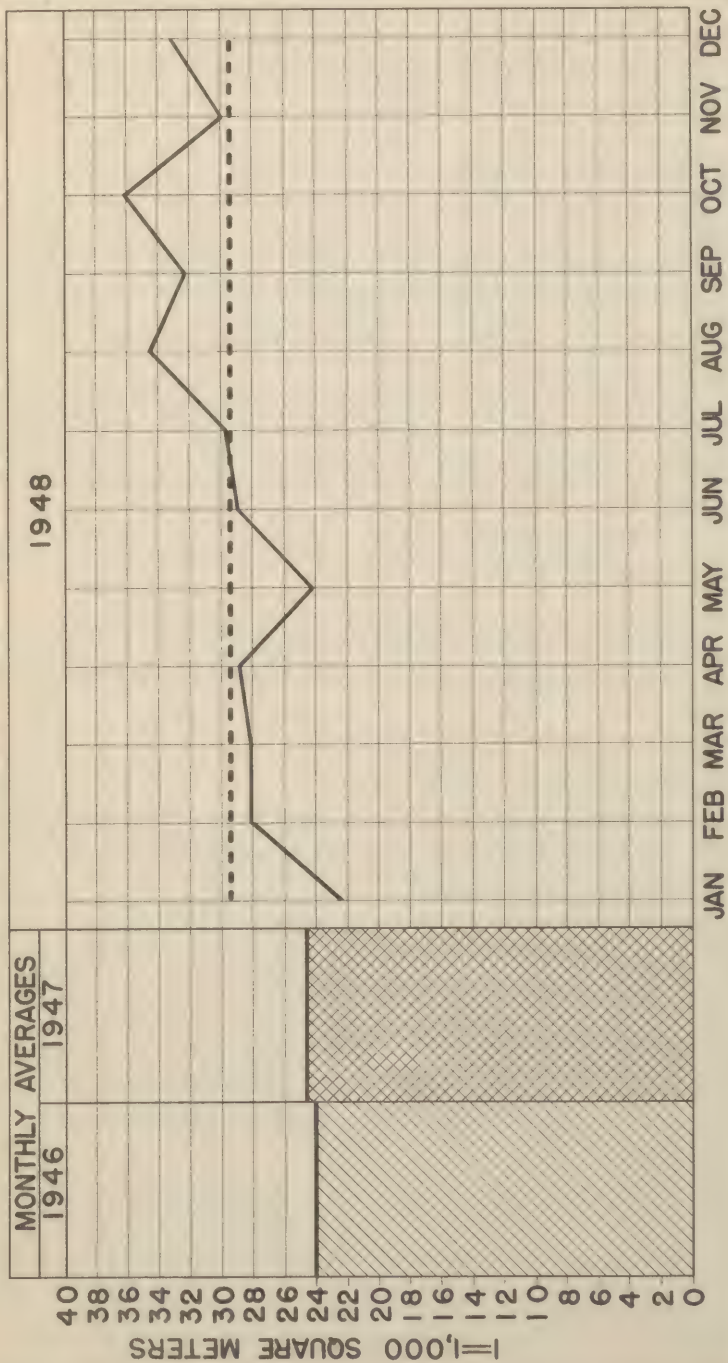
While much is yet to be accomplished from the quality standpoint, the production from the quantity standpoint has increased steadily until current supply meets all domestic demands and allows for export (Ref. Charts 56, 57).

Distribution of Medical Items

An early study made of the distribution system governing medical supplies and equipment showed that to a great extent responsibility for distribution had been delegated to control associations. Professional associations of doctors, dentists, veterinarians and pharmacists, also assisted in the distribution of medicines. The necessity for a thorough revision was recognized and initial plans were laid to transfer responsibility for control of short supply items to Japanese Government officials. However, numerous basic changes were necessary in the entire economic system before a complete revision of the distribution system could be accomplished. Emphasis was placed upon refinements in the standard operating procedures which had been employed prior to the occupation. The Ministry of Welfare officials began to take a more active interest in the national allocation plan with a view to effecting more equitable distribution.

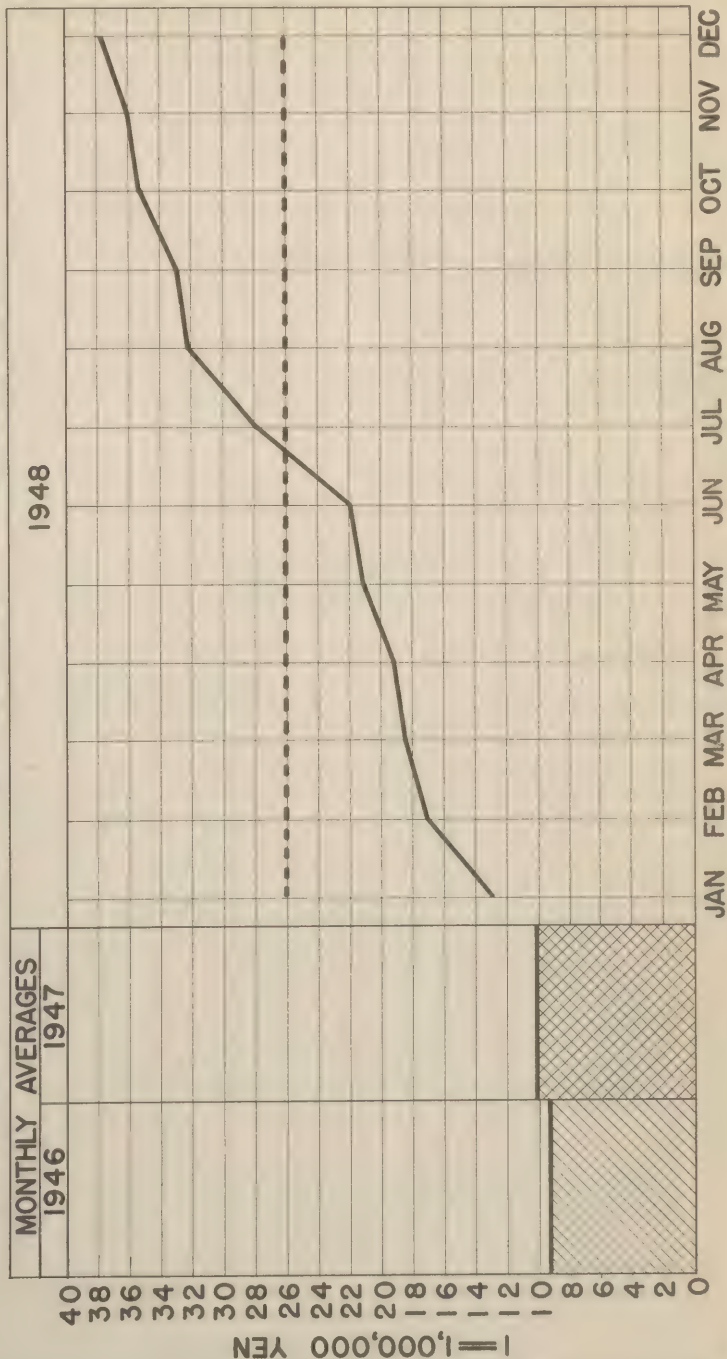
Essential medical items that are in short supply are distributed through control channels. These include drugs, surgical dressings and infant foods. They represent the more important items required in modern medical practice. Initially, the distribution of 365 such items was controlled by the Japanese Government. As improvement of production facilities and increased quantitative production was accomplished, the number of these controlled items was reduced to 79 by the end of the 1948 calendar year.

PRODUCTION X-RAY FILM

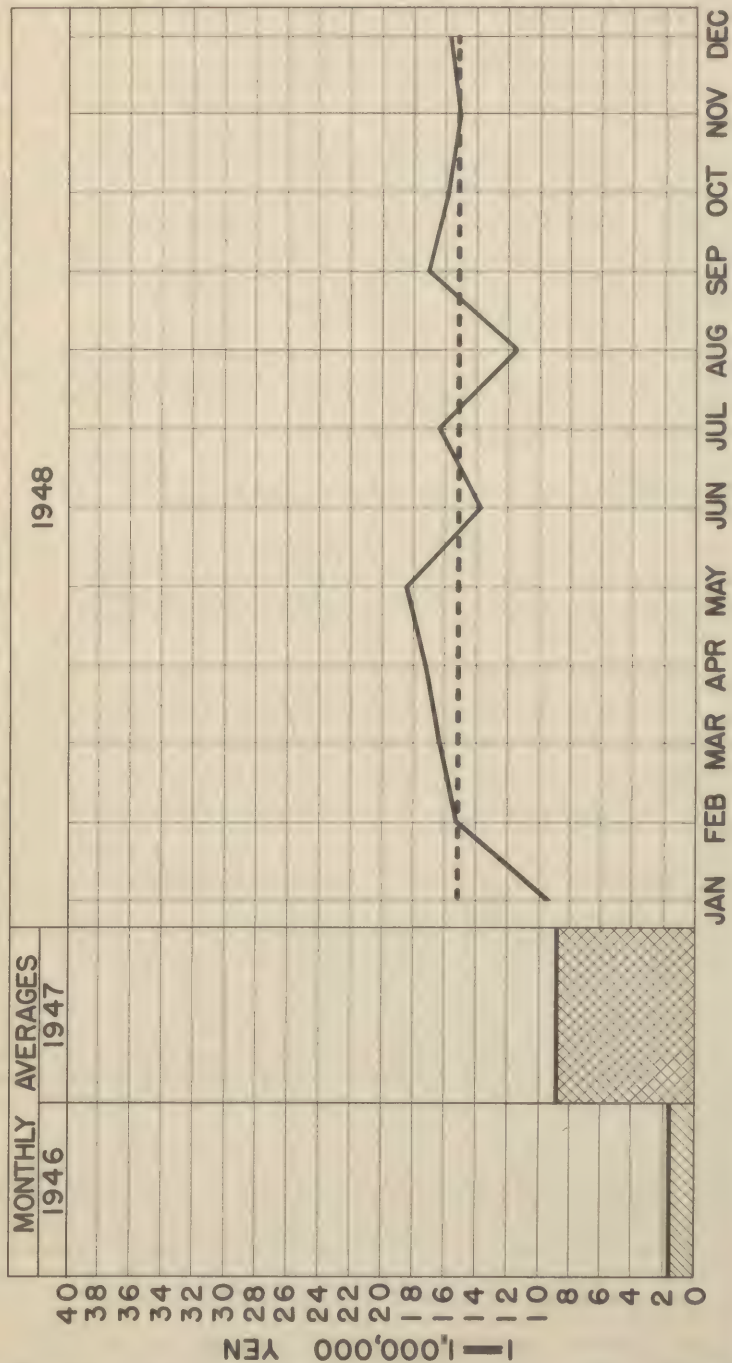


(55) PH & W/HS CHART NO. 3-25 25-3-1549

PRODUCTION MEDICAL INSTRUMENTS



PRODUCTION DENTAL INSTRUMENTS



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The distribution system has been completely revised. The control companies both centrally and locally were liquidated following the inauguration of a new ration distribution system late in 1947. Under this system, items designated by the Japanese Government for control are allocated quarterly to local governments by the Minister of Welfare, based on anticipated production quotas. These are in turn reallocated by prefectural governors to practitioners, clinics, hospitals, and pharmacies, to be redeemed by ration credentials issued by the governors to the authorized individuals and agencies. Under this system the control of distribution is exercised by the central and local governments rather than by the commercial and professional bodies as under the system it replaced. This ration distribution, too, accomplishes the free flow of critical materials through normal commercial channels from manufacturers through licensed wholesalers to the purchaser.

The improvement in equitable and efficient distribution of critical supplies has been amply demonstrated in the year of its operation before the end of 1948. The goal is to remove all unnecessary controls as soon as conditions of supply warrant.

Physical Rehabilitation of Public Health Facilities

To improve the medical care it was necessary to rehabilitate the hospitals and other public health facilities. Physical rehabilitation has been possible through allocations of building materials including cement, lumber, nails, etc. for hospital, sanitorium and clinic use.

The extreme shortages of coal and other fuels has necessitated reduction in supply to hospitals. Allocations are made to assure that necessary quantities are provided for heating and sterilization. The program for providing coal for use in hospitals has progressed satisfactorily. All hospitals are assured of adequate quantities for essential activities. However, it is not possible to make large amounts available for overall heating of hospitals, sanitoriums and clinics.

The availability of cement and other building materials permitted allocations to firms engaged in medical and pharmaceutical supply production. Thus manufacturers were able to partially rebuild portions of their damaged plants and to improve plant facilities, contributing to the increased production of necessary medical supplies.

Public sanitation facilities have been supplied with substantial allocations of cement to permit their partial rehabilitation and reconstruction. Such installations as water supply facilities, sewage disposal facilities, drainage ditches, food handling establishments, public bath houses, crematoria, and the like have received due consideration.

During the year 1948 allocations for the above uses totaled 919,400 metric tons of coal and 61,863 metric tons of cement. Of these totals 217,000 tons of coal and 6,000 tons of cement were for medical supply industries, the remainder for other public health purposes.

Repatriation Supplies

The extensive repatriation program required the distribution of large quantities of miscellaneous items, such as drugs, vaccines, surg-

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ical dressings, surgical instruments and appliances, hospital equipment and clothing. Under direct supervision, the Ministry of Welfare handled this problem in a highly satisfactory manner. It was necessary to ship vaccines and other supplies to China, Manchuria, Netherlands East Indies, and other areas included in the repatriation program. During the early stages it was necessary to supplement Japanese supplies with a limited amount of U.S. material, such as surgical dressings, instruments, sterilizers, syringes and needles.

Relief Supplies

The Japanese government had made little progress in establishing relief supply agencies on the national level. Such relief supplies as were provided were furnished by various local government and private organizations. Distribution of relief supplies was deemed a local problem and to a great extent was handled by neighborhood associations. A relief supply agency was developed under the Ministry of Welfare for the purpose of estimating requirements and directing distribution of relief supplies.

Disaster Relief Supplies

Surplus U.S. Army supplies have been used exclusively for relief during times of disaster to supplement indigenous supplies during and since the major earthquake in southern Japan in December 1946. This earthquake demonstrated the need for providing disaster relief on a national basis. The National Disaster Law was enacted 18 October 1947. The earthquake and typhoon in 1948 afforded opportunity to demonstrate the efficiency of disaster relief plans provided under this law. Supplies had been stored in warehouses strategically located for accessibility in times of disaster. Prompt action and extensive liaison between various government agencies and occupation authorities resulted in Japanese disaster relief supplies, including medicines, sanitation supplies, food and clothing being moved promptly into stricken areas. Quantities were adequate to meet emergency needs.

Release of Quinine from Impounded Stocks

The Japanese Government accumulated large stocks of quinine before and during the war, some of which was looted from allied countries. The Government was directed during 1946 to make a complete inventory of all cinchona and quinine stocks in Japan. In subsequent directives the Japanese owned quinine and cinchona products were released for distribution under Ministry of Welfare control.

The amount of quinine released (86 metric tons) was estimated to be sufficient to meet Japanese requirements until 1950, precluding the necessity of scheduling quinine for import.

Transportation Facilities, Public Health Activities

In the beginning of the occupation, motor vehicle transportation was far from adequate due to the commandeering of vehicles for Japanese military purposes. Although the Japanese have an excellent rail system there was need also for motor transportation for carrying out public health and welfare work in the more isolated sections as well as within the city limits. Urgent requirements existed for ambulances, sanitation trucks, also trucks for carrying foodstuffs and other relief supplies. Early in 1947 the U.S. Army declared a surplus of motor vehicles (ambulances and trucks) and by sale to the Japanese Government a total of 878 vehicles, consisting of 422 trucks, 145 ambulances and 320 trailers were made available to the Ministry of Welfare for use throughout the 46 prefectures.

There are limited numbers of automobiles in Japan. Initial cost, expensive operation and fuel scarcity are problems, few hard surface roads exist. Bicycles are therefore the most practical answer to road transportation problems in Japan, especially for short distance in rural areas. Many of these are equipped with side cars and trailers and are used for transportation of supplies. The number of bicycles available for use in health and welfare programs was woefully short of the total required. The situation tended to improve somewhat as time passed, becoming much better during the latter part of 1948. Progressive improvement in transportation facilities has been accomplished.

Pharmaceutical Affairs Law

With the passage on 30 June 1948 of the new Pharmaceutical Affairs Law, the Japanese Diet instituted sweeping reforms in pharmaceutical affairs in Japan. This law became effective 29 July 1948 and enforcement regulations were promulgated on its authority by the Minister of Welfare 15 August 1948. The law controls pharmaceutical affairs in Japan, defined as those activities which are related to the manufacture, preparation, sale or other distribution of materials and equipment used in the administration of preventive or therapeutic measures of disease control.

The Law provides that all drugs, devices, and cosmetics meet the requirements and conform to the standards of quality and provisions of labeling set by the Ministry of Welfare. It creates a National Board of Pharmacy whose members are appointed from among leaders in the fields of medicine, pharmacy, and education. This Board makes recommendations for standards to the Minister of Welfare.

The Law further provides that pharmacists will not be licensed unless they have been graduated from accredited colleges or universities and have passed the National Pharmacist Examination conducted by the National Board of Pharmacy. Licensing of pharmacies, manufacturers and sellers of drugs and devices is required. False and misleading advertising is prohibited. The sale of poisons and powerful drugs is regulated. Sulfanilamide and its derivatives, penicillin and streptomycin are not permitted in distribution unless they are labeled to signify that their use is pursuant to the prescription or under the

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direction of a physician, dentist, or veterinary surgeon. Heavy penalties are provided for violations of the provisions of this Law.

Pharmaceutical Associations

The Japan Pharmacists Association and similar associations in the various prefectures were dissolved under the provisions of the Pharmaceutical Affairs Law. These associations were formerly under strict government influence and membership was compulsory. New associations have been formed along democratic principles, one in each prefecture, and a Japan Pharmaceutical Association on a national level. The national association was formally established in the Fall of 1948. Membership is on a voluntary basis and is limited to licensed pharmacists. Associate membership may be extended to other than licensed pharmacists who are engaged in pharmaceutical affairs.

Pharmaceutical Education

Standards of pharmaceutical education in Japan were raised from those of a technical school level to those of college and university level. A temporary council was established to make recommendations on improvement of pharmaceutical education. This pharmaceutical council was absorbed into the Japan Pharmaceutical Association and functions as the Educational Committee of this Association. This council has assisted in establishing school standards, in the rehabilitation of school buildings and in the improvement of curriculums. They have established committees for inspection of pharmaceutical schools, to observe the efficiency of teaching techniques and the maintenance of established standards for pharmaceutical educational institutions. A four-year course in pharmacy has been established and is expected to go into full operation in 1950. The curriculum requires basic cultural subjects as well as scientific and technical subjects and training.

Fiscal - Ministry of Welfare Budget

The administration of public health and welfare programs requires adequate funds. Since this administration is a function of the government agencies concerned, it is necessary to provide sufficient appropriations to cover the cost during the fiscal period. The Japanese economy necessitates that careful consideration must be given to each appropriation planned to insure that public funds will be used to the best advantage in the overall economy and welfare of the nation.

Public health and welfare programs are such that money invested in them does not produce revenues which are readily demonstrated on a balance sheet. For this reason the public officials who plan for these programs, and for the necessary budgets for their implementation, are required to exhibit constant vigilance and diligence to convince budgetary authorities of the value, to the overall economic recovery of the nation, of the monies so expended. It has been demonstrated from statistics that an investment in the preventive medicine program alone in 1948 of approximately 1.2 billion yen has saved the nation 109.9

billion yen in medical care costs and wage losses which would otherwise have resulted due to morbidity and mortality.

The Japanese fiscal year covers the period 1 April through 31 March. Budget estimates are prepared separately by each ministry and are integrated by the Ministry of Finance into a national budget for presentation to and approval of the Cabinet. The budget as approved by the Cabinet is presented to the Diet for enactment into law.

The Ministry of Welfare budget estimate is carefully screened by the Public Health and Welfare Section to determine that public health and welfare programs necessary to fulfill the objectives of the occupation are adequately provided for in conformance with the economic ability of the nation to support such programs. Changes, additions and deletions are recommended to the Ministry of Welfare and to the SCAP authorities responsible for overall budgetary control. Deficiency budgets are likewise formulated and studied, where economic changes during the fiscal year have made appropriate funds insufficient to cover total costs. Such appropriations are provided by supplementary budgets duly enacted into law by the Diet when and if required.

Public health and welfare programs are not carried out entirely by the Ministry of Welfare. Although the Ministry of Welfare is responsible for the overall nationwide public health and welfare program, certain responsibilities, as specified in appropriate laws, are delegated to local governments. In such cases, and as required by law, the national government provides grants-in-aid to prefectures, cities, towns and villages. The percentage of total cost thus provided may be definitely stipulated in the applicable law, or may be enabling within specified limits. Such national aid is required under existing conditions because the degree of local revenue is frequently limited. The local government is assured of its national grant-in-aid only if it includes in its own budget, appropriations to cover its share of the total cost of a project.

Appropriations for the Ministry of Welfare have been made since 1937 as tabulated below:

(*) Japanese FY	Total Appropriations in Yen	Cost of Living Index (1933 equals 100)
1937	¥ 63,950,865	132.3
1938	160,516,164	139.6
1939	146,673,170	154.2
1940	154,536,311	172.9
1941	194,385,129	183.4
1942	254,888,632	199.2
1943	423,328,829	209.1
1944	515,516,561	233.1
1945	637,957,960	297.5
1946	7,248,825,320	1,407.1
1947	13,377,654,000	4,524.8 (April)
		5,697.8 (September)
1948	21,521,715,000	12,000.0 (Approx)

(*)The year represents in each case the Japanese fiscal year, which begins 1 April of the calendar year stipulated and continues through 31 March of the following calendar year. Thus the 1948 fiscal year is from 1 April 1948 through 31 March 1949.

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Fiscal - U. S. Appropriated Funds

Another phase of fiscal activity in Japan is the planning for expenditures of funds appropriated by the United States Congress for Government and Relief in Occupied Areas (GARIOA) and for Economic Rehabilitation of Occupied Areas (EROA). This control is entirely within SCAP agencies, subject to approval from the Department of the Army in Washington. GARIOA funds are appropriated based on criteria of prevention of widespread disease and unrest which would hamper in any way the aims of the occupation. EROA funds are those to aid in the economic rehabilitation and recovery to carry out that phase of the occupation aims.

In coordination with other SCAP staff sections, the Public Health and Welfare Section formulates plans for budget estimates for medical and public health supplies, food and personnel to be supplied with U.S. appropriated funds. Careful consideration is essential to assure that the cost of the occupation to the American taxpayer is kept at a minimum, and successively reduced as occupation aims are accomplished. Such reduction has progressively been made. The 1947 fiscal year (U.S.) appropriation for medical supplies for Japan was approximately \$10,000,000. In the 1949 fiscal year (U.S.) less than \$3,000,000 was appropriated for Japan for this same purpose.

Chapter 10

NARCOTICS

Pre-Occupational Summary

No control over narcotics existed in Japan at any time prior to the surrender. Emphasis was placed on production of narcotics, from opium and coco leaves imported from Manchuria, Mongolia, Formosa, Iwo Jima, Okinawa and the Middle East, with complete disregard of international obligations to limit and report such transactions to bodies charged with regulating the supply and distribution of narcotics throughout the world.

Figures of production, as furnished by the manufacturers to the Japanese Government, were maintained in Japanese Government files but "planned" figures showing, for instance, one-sixth of the actual production of heroin were submitted to the Supervisory Body of the League of Nations as true figures. Heroin was shipped from Japan and Korea to Manchuria in quantities that would more than suffice for total world requirements.

At the beginning of the occupation, narcotics, both finished and crude, were scattered throughout Japan in caves, medical depots, Army and Navy hospitals and other military and industrial establishments.

Japanese reports always indicated a comparative scarcity of narcotic addicts. This was contrary to presumptions since any doctor or pharmacist in Japan could purchase and dispose of any amount of narcotics without being required to maintain records.

Prohibition of Growth, Manufacture and Exportation

After determining the laxity of controls that existed over narcotics in Japan, the Japanese Government was immediately directed to:

1. Prohibit the planting, growth and cultivation of narcotic seeds and plants.
2. Prohibit the manufacture and exportation of narcotics.
3. Enact laws establishing strict centralized control over narcotics.
4. Establish a narcotic enforcement agency extending throughout every prefecture in Japan.
5. Destroy all heroin, a high-tension, dangerous narcotic formerly reaching illegal markets in the United States.

It was decided that importation of narcotics would be limited to

the amounts deemed necessary for medical treatment of the Japanese people. In the fall of 1945 after the growth, manufacture and exportation was prohibited, all crude and semi-processed narcotics were taken into custody by the occupation forces. All former Japanese Army and Navy medicinal narcotics were likewise taken into custody, inventoried and stored. These medicinal narcotics have since been turned over to SCAP approved wholesale houses for repackaging and distribution under strict control regulations which were enacted into Japanese law in June 1946 and incorporated into a new law passed by the Diet on 28 June 1948.

Narcotic Control

Regulations

Legislation establishing a strong centralized control over the distribution of narcotics by dealers was enacted following six months of conferences and preparation. Dealers, numbering approximately 93,000, must register annually and submit periodic reports. Every transaction by the dealers, who are required to follow prescribed procedures, is reported monthly to the Japanese Government through prefectural offices and, in turn, forwarded to SCAP. These summaries are accurate statements on the working stock (wholesaler's stocks) of narcotics in Japan, and give detailed information of violations, seizures, thefts, arrests and convictions.

These controls were the result of ministerial regulations. It was recognized that a new narcotic law, to embody all the principles of effective narcotic control, was essential. After numerous conferences, a proposed bill was submitted to the Diet and became Law No. 123 on 28 June 1948, effective from 10 July 1948.

The new Narcotic Control Law continues in effect, as law, the strict provisions of SCAP directives and ministerial regulations under which narcotics have been brought under control during the past three years. The law provides that persons who are addicted to narcotics so as to be a menace to the public welfare because of their addiction, or to lose their self-control because of their addiction, shall be subject to penal servitude of not less than six months, nor not more than one year. The maximum penalty under the law is five years penal servitude or ¥50,000 fine, or both. There is a gradation of penalties written into the law to encourage the courts to assess severe penalties for serious violations.

Regulations effectuating the provisions of the Narcotic Control Law were promulgated on 13 July 1948.

In addition to the Narcotic Control Law, a Marihuana Control Law (Law No. 124) also passed the Diet on 28 June, effective from 10 July 1948. This law provides that marihuana can only be grown for fibre purposes. It limits the areas for such production, and continues in effect the strict controls which have been operative as the result of

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SCAP directives.

The maximum penalty provided by the law is three years penal servitude or ¥30,000 fine, or both.

A Poison Control Law (Law No. 206), passed by the Diet on 18 December 1947, regulates the manufacture, labeling, storage and distribution of poison and powerful agents. Records of sales must be maintained and sales to persons under 14 years of age are prohibited.

The Pharmaceutical Affairs Law (Law No. 197), which passed the Diet on 30 June, carries a provision that a drug containing any quantity of narcotics or hypnotic substance shall carry a label with the name, quantity and percentage of said substances and derivatives thereof and in juxtaposition thereto, the quotation "Warning - May be Habit Forming".

Enforcement Agents

During 1946, basic principles of proper narcotic control were firmly established. In cooperation with Government officials, a Narcotic Section of 40 persons was created in the Ministry of Welfare on 2 April 1947.

Upon the inauguration of the Narcotic Section of the Ministry of Welfare, narcotic officials were stationed throughout Japan in each prefecture to supervise and investigate narcotic control in their respective areas. From among these officials, the Ministry of Welfare designates narcotic agents to have power of arrest for narcotic and marihuana violations as provided by the Diet in September 1947. As authorized by an amendment to the Narcotic Law, effective 1 January 1949, the number of narcotic agents may be increased to 250. At the present time there are 154.

Diet action in granting power of arrest to narcotic agents made the enforcement of the narcotic law much more effective. As early as December 1947, these agents, working with Occupational Force law enforcement personnel, were responsible for apprehending 14 foreign nationals in one area who were illegally dealing in heroin and opium proved to have originated outside Japan. By the end of 1948, the agents were effectively combating traffic in drugs smuggled into Japan. Numerous arrests of foreign nationals and Japanese resulted in the seizure of a clandestine laboratory and cutting plant. The laboratory was being used to process crude drugs smuggled into Japan. Thefts of narcotics were curtailed by limiting the purchases of narcotics by registrants, who were burglarized, to minimum amounts until they improved storage security and received approval by the Narcotic Section.

The following is a summation of narcotic control enforcement activities in Japan for the 24 months ending 31 December 1948:

Registrants inspected
Investigations originated

46,919
4,404

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Arrests - Registered persons	413	
Unregistered persons	1,218	
Total		1,631
Convictions - Registered persons	179	
Unregistered persons	590	
Total		769

Of registrants convicted, 61 received sentences totaling 50 years and 5 months penal servitude, and 130 received fines totaling ¥380,846. Of non-registrants convicted, 305 received sentences totaling 312 years and 8 months penal servitude, and 130 received suspended sentences totaling 305 years and 6 months. Four hundred thirty-one non-registrants, including 89 of those sentenced to penal servitude, were fined a total of ¥1,386,900.

Thefts averaged 37 per month in 1947. This was reduced to 26 per month in 1948.

Agents operate under supervision and direction from new narcotic officials in the Ministry of Welfare who have no connection with the former narcotic policy in Japan. They work in close liaison with the police and receive continuing instruction and guidance in narcotic investigative procedures from SCAP narcotic control personnel.

Training Schools

In March 1948 a training school was held in Tokyo for the chief narcotic agent from each prefecture in Japan. Practical demonstrations were given by SCAP narcotic control personnel, officials of the Narcotic Section, Ministry of Welfare, and officials of the Prosecution Section, Attorney General's Office.

In May and November 1948, additional schools were held for the remaining narcotic agents. These schools, which have immeasurably aided enforcement personnel in becoming more familiar with their responsibilities, will be a continuing part of the narcotic control program to train agents in modern investigative procedure.

Cultivating Hemp for Fibre

Economic necessity, as well as the marked advances made in the proper control of narcotics, made it imperative that certain changes be made in the narcotic control program.

In January 1947, to relieve the acute shortage of fishing ropes and nets, hemp was authorized to be cultivated for fibre purposes in certain areas limited to an over-all total of 5,000 hectares (1 hectare equals 2.45 acres). The authority to grow hemp is now contained in the new Marihuana Control Law.

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Sales and Distribution

Sales and distribution of narcotics are strictly controlled under the new Narcotic Control Law. Wholesalers and dealers are required to submit reports of all transactions each month and careful surveillance is maintained over these wholesalers and dealers through regular inspections by narcotic enforcement agents. In addition, all dealers are required to maintain proper security storage for all narcotic stocks with the vaults of wholesalers being further required to have proper sanitation, etc. Access to such areas is not permitted to any person who is not authorized and properly identified. Employees of wholesale firms are carefully screened and selected.

Druggists' and pharmacists' records are carefully checked by narcotic enforcement personnel and discrepancies are promptly handled by warning the dealer and, in cases of willful violation, prosecution follows.

Narcotics which were regarded as the most difficult item to control in Japan, were the first medicines to be placed on a free-trade basis for distribution.

Prices are controlled and sales are restricted to minimum amounts as needed by registrants. Every transaction must be made a matter of record, including the narcotics administered to a patient by a practitioner.

Accurate reports, which are assembled by the Japanese Government covering every phase of the narcotic control program, are forwarded to the United Nations Commission on Narcotics and to the United Nations Opium Board. Favorable comment has been received from these agencies regarding the effective control measures now operative and also the manner in which enforcement has been carried out.

Addicts

Japanese reports prior to the occupation have always indicated a comparative scarcity of narcotic addicts. Due to data obtained on the laxity of narcotic control a continued effort has been made to determine the number of addicts in Japan and has resulted in information on approximately 5,076 such persons. Such addicts are kept under surveillance and the new narcotic law provides that treating an addict with narcotics is prohibited.

Under the new law, addicts can be hospitalized and given treatment cures until considered under control and not a hazard to the public welfare.

Conclusion

Japan has been eliminated as a source of illicit narcotic traf-

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ficking. Narcotic officials in the Ministry of Welfare and the narcotic enforcement agents throughout the nation have performed a commendable job in carrying out their responsibilities.

Future programs will be directed toward improved narcotic medication standards, in addition to improving enforcement control by narcotic agents as well as by prefectural procurators who present all narcotic violations to the courts.

Improved security measures to be undertaken by registrants holding large stocks of narcotics will tend to prevent diversion and limit trafficking into underworld sources. Special cognizance will be taken of any attempt to establish any international lines of trafficking either into or out of Japan.

